

**“We are entitled to some control”: The Australian Army
Medical Corps in the First World War**

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Abstract

This thesis examines the work of the Australian Army Medical Corps (AAMC) in the First World War. It challenges assumptions about how, by whom, and for what reasons decisions were made about the medical care provided to Australian soldiers serving in the Australian Imperial Force (AIF). The factors that were understood to qualify a person to control Australian military medicine changed over the course of the war and this thesis explains the reasons for those changes. It also examines the political manoeuvring that facilitated the shifting of medical-military power to the control of Australian medical men. This thesis compares and evaluates the plans for casualty retrieval and evacuation on the battlefield in the Gallipoli Campaign in 1915 and in the major battles in which the AIF participated on the Western Front in 1916, 1917, and 1918. It discusses the conflicts that arose between the Australian medical services and their British counterparts not only in the front lines but also in the realms of preventative and restorative medicine by analysing the role and provision of rehabilitation services and the response to the problems posed by venereal disease.

I argue that the AIF became more ‘medicalised’ over the course of the war with the increasing involvement of medical personnel in situations that had not previously been medical responsibilities. I demonstrate that decisions about medical care for Australian soldiers were increasingly made by Australian medical men for medical rather than military reasons. I propose that their identity as civilian doctors working in a military context is paramount in understanding their decision-making processes as well as comprehending the opposition they faced. Thus, this thesis demonstrates that, as the war progressed, the AAMC exerted greater control over medical care for Australian soldiers, but when this control was not granted by Britain, it was sought and claimed by the Australian representatives. The AAMC operated at the intersection of imperial, military, medical and gender hierarchies and this thesis analyses the ways in which these traditional hierarchies were, at various times, blended, transgressed, reinforced, subverted, and upheld.

This thesis contributes to an understanding of the development of Australian military medicine in the early twentieth century, which has been obscured by a narrow focus on a select group of individuals. Utilising unit war diaries as well as the orders, memoranda, and reports issued by the Australian Army Medical Corps and associated units provides insight into the thinking behind the medical provisions and enables an analysis of not just medical

events, but how they were understood by medical officers. Furthermore, by critiquing the work of the AAMC within its context as a member of the broader British Expeditionary Force's medical efforts, this thesis highlights the on-going renegotiation of the relationship between Australia and Britain that was evident in this period. This thesis is innovative in integrating an analysis of frontline medicine with that found behind the lines and demonstrating that similar principles existed in both areas despite the presence and involvement of different actors.

Declaration

I certify that this work contains no material which has been accepted for the award of any other degree or diploma in my name, in any university or other tertiary institution and, to the best of my knowledge and belief, contains no material previously published or written by another person, except where due reference has been made in the text. In addition, I certify that no part of this work will, in the future, be used in a submission in my name, for any other degree or diploma in any university or other tertiary institution without the prior approval of the University of Adelaide and where applicable, any partner institution responsible for the joint-award of this degree.

I give consent to this copy of my thesis, when deposited in the University Library, being made available for loan and photocopying, subject to the provisions of the Copyright Act 1968.

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I acknowledge the support I have received for my research through the provision of an Australian Government Research Training Program Scholarship.

Signed:

Date: 26 June 2017

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My niece, born nine days after my candidature commenced, recently declared that she wanted to be a ‘why-er’ (later translated to scientist) because she likes asking why. Miss Zoe Claire Moncrieff, this thesis is dedicated to you in the hope that you never stop.

List of Abbreviations

1AD	1st Australian Division
2AD	2nd Australian Division
3AD	3rd Australian Division
4AD	4th Australian Division
5AD	5th Australian Division
AA&QMG	Assistant Adjutant and Quartermaster General
AAH	Australian Auxiliary Hospital
AAMC	Australian Army Medical Corps
AAMS	Australian Army Medical Services
AANS	Australian Army Nursing Service
ACCS	Australian Casualty Clearing Station
ACD	Australian Command Depot
ADH	Australian Dermatological Hospital
ADMS	Assistant Director of Medical Services
ADS	Advanced Dressing Station
AFA	Australian Field Ambulance
AGH	Australian General Hospital
AIF	Australian Imperial Force
AMC	Army Medical Corps
ANZAC	Australian and New Zealand Army Corps
ASH	Australian Stationary Hospital
AWM	Australian War Memorial
BEF	British Expeditionary Force
CCS	Casualty Clearance Station
CGS	Chief of the General Staff
CO	Commanding Officer
DADMS	Deputy Assistant Director of Medical Services
DAG	Deputy Adjutant General
DAQMG	Deputy Adjutant and Quartermaster General
DC	Dardanelles Commission
DDMS	Deputy Director of Medical Services
DGAMS	Director General, Army Medical Services

DGMS	Director General, Medical Services
DMS	Director of Medical Services
GHQ	General Headquarters
GOC	General Officer Commanding
GP	General Practitioner
LHCMA	Liddell Hart Centre for Military Archives at King's College, London
MDS	Main Dressing Station
MEF	Mediterranean Expeditionary Force
MO	Medical Officer
NAA	National Archives of Australia
NCO	Non-Commissioned Officer
NCCVD	National Council for the Combatting of Venereal Disease
NLS	National Library of Scotland
NZEF	New Zealand Expeditionary Force
OC	Officer Commanding
PDMS	Principal Director of Medical Services
PHTO	Principal Hospital Transport Officer
PUO	Pyrexia of Unknown Origin
QMG	Quartermaster General
RAMC	Royal Army Medical Corps
RAP	Regimental Aid Post
RDS	Reserve Dressing Station
RMO	Regimental Medical Officer
SMO	Senior Medical Officer
TNA	The National Archives (UK)
UK	United Kingdom
VAD	Voluntary Aid Detachment
VC	Victoria Cross
VD	Venereal Disease
WAAC	Women's Auxiliary Army Corps
WL	Wellcome Library
YMCA	Young Men's Christian Association

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Note on Style

Throughout this thesis both Anzac and ANZAC are used. ANZAC signifies the acronym of Australian and New Zealand Army Corps and refers to the military unit(s), whereas Anzac is used in discussions of the Anzac spirit or Anzac legend etc.

As much as possible the original wording, grammar and capitalisation has been retained when quoting from sources. In a number of instances the punctuation in the original text significantly detracts from its readability and so the punctuation has been altered and an indication given in the footnotes. None of these grammatical interventions alter the meaning of the quotes.

When referring to an individual's rank and position I have used their rank at the time the source was produced; thus, some individuals are referred to in multiple ways throughout this thesis.

Introduction

More Than a Man and His Donkey

The First World War has taken on peculiar meaning in Australian culture with the ensuing Anzac legend described as having “extraordinary currency ... in contemporary Australian society”.¹ Books concerning the history of Australian involvement in the war fill many shelves in local libraries yet relatively little is known of the work of the Australian Army Medical Corps (AAMC) beyond the iconic image from the Gallipoli campaign of John Simpson Kirkpatrick and his donkey (or donkeys depending on which accounts you read).² Their story has become synonymous with the Anzac legend; they are the subjects of numerous histories³ and children’s picture books.⁴ Their likenesses have been cast in bronze and placed at the entrance to the Australian War Memorial in Canberra and on the banks of the River Torrens in Adelaide. They are the stuff of legend. Yet there is, of course, much more to the story of Australian medicine at Gallipoli, and in the First World War after 1915, than the exploits of this one man and his four-legged friend.

The Australian medical services were integral to the work of the Australian Imperial Force (AIF) in the First World War. Colonel Arthur Graham Butler, initially Commanding Officer of the 3rd Australian Field Ambulance before becoming the official historian of the Australian Army Medical Services in the First World War, suggested that sixty per cent of the Australian force in the lines in 1918 were men who had recovered from previous illness or injury.⁵ Though it is unclear from his prose whether he was referring to those recovered from influenza or all those returned to duty irrespective of the type of illness or injury, these statistics give an indication of the importance of the work of the medical services to

¹ Carolyn Holbrook, *Anzac, the Unauthorised Biography* (Sydney: NewSouth Publishing, 2014), 1.

² Graham Wilson, *Dust Donkeys and Delusions: The Myth of Simpson and His Donkey Exposed* (Sydney: Big Sky Publishing, 2012), ii–iii.

³ C. Irving Benson, *The Man with the Donkey: John Simpson Kirkpatrick, the Good Samaritan of Gallipoli* (London: Hodder and Stoughton, 1965); Peter Cochrane, *Simpson and the Donkey: The Making of a Legend* (Melbourne: Melbourne University Press, 1992); Tom Curran, *Across the Bar: The Story of “Simpson”, The Man with the Donkey: Australia and Tyneside’s Great Military Hero* (Brisbane: Ogmios Publications, 1994).

⁴ Mary Small, *Simpson and Duffy* (Sydney: Harcourt Brace Jovanovich, 1989); Tom Curran, *Not Only a Hero: An Illustrated Life of Simpson, the Man with the Donkey* (Brisbane: Anzac Day Commemoration Committee (Queensland), 1998); Mark Greenwood, *Simpson and His Donkey* (Sydney: Walker Books, 2008); Jackie French, *The Donkey Who Carried the Wounded* (Sydney: HarperCollins Australia, 2010); Peter Stanley, *Simpson’s Donkey: A Wartime Journey to Gallipoli and Beyond* (Sydney: Murdoch Books, 2011).

⁵ Arthur G. Butler, *The Australian Army Medical Services in the War of 1914-1918: The Western Front*, vol. 2 (Canberra: Australian War Memorial, 1940), 605.

the efficient functioning of the army. David Noonan's statistical analysis of the AIF exposed flaws in Butler's history.⁶ He found that the men who made it to a theatre of war were admitted to hospital as a result of wounds, injuries and illnesses on over 737,000 occasions. If hospitalisations for venereal disease are included the number is well over 750,000. In the official account Butler suggests that wounded soldiers were hospitalised on only 155,000 occasions, so Noonan's number is around five times higher than Butler's.⁷ Butler's analysis was based on the statistics he collected which have now been shown to be inaccurate, and not by a small margin. Noonan's new statistics go a long way toward explaining why the medical services were under sustained pressure throughout war, but he does not provide an analysis of how the medical services coped with the scale of the casualties. Therefore, in light of Noonan's results, Butler's examination of broader problems over the course of the war, which rely on his statistics, warrant revisiting in order to establish whether his conclusions regarding the efficacy of the AAMC are still valid.

This thesis asks how medical care was provided to Australian soldiers in the First World War, where those sites of medical-military authority were located, and contextualises them in order to determine the factors that underpinned the structures of medical care in the AIF. It does so by examining the AAMC's provision of three different types of care: casualty clearance and evacuation in battle, the rehabilitation of soldiers for a return to duty, and the prevention and treatment of venereal disease. The investigation of these three forms of medical care enables an analysis of three important points of contact between doctors, patients and the army. Each significant in their own right, these sites of care were places where the AAMC exercised control over Australian soldiers' bodies. They were also sites at which imperial, military, medical, and gender hierarchies were variously blended, transgressed, subverted, reinforced, and sometimes upheld as the Australian medical men of the AAMC sought to establish their expertise and authority over sick and wounded Australian soldiers.

The four hierarchies examined in this thesis are visible in the relationships between the AAMC, its officers, and other units, groups and individuals. The role of the imperial mother country in the care provided for Australian soldiers was contested with questions of national identity emerging from discussions of responsibility for care. Military

⁶ David Noonan, *Those We Forget: Recounting Australian Casualties of the First World War* (Melbourne: Melbourne University Press, 2014).

⁷ Noonan, *Those We Forget*, 135.

hierarchies subordinated civilian expertise, and so the reliance of the AAMC on civilian doctors with limited military experience required them to establish their expertise in a military context. Medical hierarchies privileged those with medical training over those without, and gender hierarchies differentiated between competing masculinities as well as promoting the masculine over the feminine. None of these hierarchies can be completely disentangled from the others. For example, as will be seen in Chapter 1, military and imperial hierarchies were blended in the structure of command for the Dardanelles Campaign. Yet these relationships were renegotiated over the course of the war and saw the emergence of Australian medical men as the primary decision makers in the provision of medical care to Australian soldiers.

This thesis commences, in Chapter 1, with an examination of the provision of medical care to Australian soldiers during the Dardanelles Campaign and explicitly examines the imperial and medical-military hierarchies that were blended and challenged during the campaign. Whilst the Dardanelles Campaign has been overstated in terms of its significance to Australian history and to the outcome of the war, it is vitally important in the development of the Australian medical services in the First World War. The chapter highlights the attempts by AAMC Officers to draw attention to deficiencies in the medical arrangements made by British Officers and analyses the AAMC's response. It also includes an analysis of the interactions between AAMC Officers and the members of the Dardanelles Commission and argues that the failure of the medical arrangements made by Britain was a significant factor in the AAMC's push to gain control of the medical arrangements for Australian casualties. As histories of the Australian medical services during the campaign at Gallipoli have already been written (as the below review of existing literature makes clear), the battle was not originally intended to be a significant part of this thesis. However, Gallipoli had lasting consequences for the medical services and the AAMC's work on the Western Front was completed in Gallipoli's shadow. In this chapter I agree with Mark Harrison's assessment of the Dardanelles Campaign, which suggests that professional expertise was not fully harnessed due to a reliance on traditional hierarchies, but I shift the focus of inquiry to the AAMC and its interaction with the rest of the MEF. The problems with the military hierarchy and the quality of the staff in command were problems faced by both the British and Australian medical services. The positions of the two medical services and their perceived value in the combined imperial services were not substantially different. Both Royal Army Medical Corps (RAMC) and AAMC officers had similar views on the role of medicine in war and the importance of including the medical

services in strategic planning. The views of Neville Howse, initially Assistant Director of Medical Services for the 1st Australian Division and later Director of Medical Services for the AIF, as well as the views of other Australians, were, however, intensified by the disregard shown for Australian medical-military expertise. This chapter examines how both of these issues combined to necessitate an independent, self-contained AAMC with control of medical issues for the AIF.

This thesis explicitly links the Dardanelles Campaign to the campaigns on the Somme and in Flanders to highlight the fact that the AAMC was working on the Western Front while the political machinations and fallout after the Dardanelles Campaign were still on-going. Without wanting to walk too far down the path of counterfactual history, I suggest that had the AAMC's first major engagements of the war occurred in the more consultative command of the Western Front, the AAMC would not have had such a compelling case for further independence in medical matters.

Chapter 2 is the first of two successive chapters that trace the work of the AAMC on the Western Front and continue to investigate the challenge to imperial, military and medical hierarchies. It focuses on the main battles in which Australian units fought in relatively stationary warfare: Fromelles, Pozières, and Mouquet Farm in 1916, and Messines and Passchendaele (the Third Battle of Ypres) in 1917. By examining the refinements made to casualty evacuation procedures between the front and the Casualty Clearing Station, this chapter demonstrates the increasing Australian control of medical care and the AAMC's departures from British plans and processes. The subsequent chapter examines what happened to those plans once the type of warfare changed to one that was comparatively mobile. Chapter 3 assesses the provision of medical care to Australian soldiers in 1918 in retreat, during the German Spring Offensive, and on the advance, during the Hundred Days Offensive. It argues that while some of the innovations made to medical arrangements the previous year had to be unwound, the return to a system more reminiscent of the one used by the RAMC was not accompanied by a return to RAMC control.

Chapter 4 marks a departure from the chronology of the first three chapters to examine the purpose, place and practice of auxiliary hospitals in the Australian medical services. It argues that the location of auxiliary hospitals between the home and the front combined with the increased presence of women to change the nature of these medical spaces. Yet, despite this, the shift toward medical control was maintained and this chapter

outlines how this was achieved. As this topic and the one that follows in Chapter 5 have literatures of their own that have emerged with a degree of independence from other medical aspects of the war, both these chapters contain their own, more specialised, historiographical discussions.

The final substantive chapter, Chapter 5, evaluates the AAMC's approach to soldiers' sexual health through an analysis of the Australian response to venereal disease (VD). In doing so I examine the ways medical approaches to disease were combined with the exploitation of the military's authority over the individual and the harnessing of prevalent ideas of gender, sex and sexuality. The chapter outlines the AAMC's changing policies to what was described as its most difficult problem in the war and argues that the AAMC was able to implement a relatively pragmatic response to the problems created by VD because of the willingness of soldiers to be proactive about their sexual health, through the maintenance of military authority, and because the policies that were enacted reinforced dominant gender norms.

In making these arguments I draw upon a disparate range of literatures that examine the imperial, military, medical and gender hierarchies examined in this thesis.

Imperial Hierarchy

Butler's Official History of the Australian medical services was the first to examine the provision of care to Australian soldiers in the First World War. Published in three volumes in 1930 (with a second edition in 1938),⁸ 1940,⁹ and 1943,¹⁰ it has remained largely unchallenged as the definitive account of the medical care provided to Australian soldiers during the war. Whilst the Official History provides the most comprehensive and complete account of the work of the medical services in the First World War it is not without its problems. Its scope leaves many questions unanswered, the statistics collated have recently been scrutinised and found wanting, and it has been implicated in the development of Australia's national creation myth.¹¹ This was, in part, because it was overseen by Charles

⁸ Arthur G. Butler, *The Australian Army Medical Services in the War of 1914-1918: Gallipoli, Palestine and New Guinea*, 2nd ed., vol. 1, 3 vols. (Melbourne: Australian War Memorial, 1938).

⁹ Butler, *The AAMS in the War of 1914-1918*, 1940.

¹⁰ Arthur G. Butler, *The Australian Army Medical Services in the War of 1914-1918: Problems and Services*, vol. 3 (Canberra: Australian War Memorial, 1943).

¹¹ Mark Harrison, *The Medical War: British Military Medicine in the First World War* (Oxford: Oxford University Press, 2010), 172.

Bean, the author of the general Official History of Australia's involvement in the war and an advocate of the "Australian Ideal".¹² The official account was intended to communicate developments in medical treatments to a wider audience yet, under Bean's influence, it also took on a tone similar to his Official History with attempts to convey to the reader the heroism, innovation and determination of the members of the Australian Army Medical Corps.

Despite covering a broad range of issues and theatres of war on three continents Butler acknowledges from the outset that an Australian medical history of the war must be limited in its scope, as the only theatre in which Australia had full responsibility for medical care was the Australian Naval and Military Expeditionary Force's work in the Pacific.¹³ In the medical sphere Australian authority did not extend outside of Australian personnel so Butler's work does not venture too far into the relationships between British and Australian medical units. Butler writes: "The study of what may be termed the medical strategy of the war belongs, therefore, properly to the Imperial history, and therein has been admirably presented."¹⁴ Whilst Australian authority did not extend beyond Australian units, officers of the AAMC did attempt to influence the plans that were made by their British counterparts and discussion of these examples feature in the official account. Butler did acknowledge that there was conflict in this relationship. He wrote:

the carrying out in a dominion army of certain principles laid down by the medical authorities of the British Army opens up the whole field of the relations of the dominion service to that of the Mother Country, by the side of which it took its place in the war organisation of the British Empire. The problems involved in this relationship, and the experience of the medical service in their gradual solution, are matters which, so far from possessing a merely academic interest, come white-hot from the furnace in which have been moulded the latest changes in the British Commonwealth of Nations.¹⁵

Butler suggests that conflict between the Australian medical services and the British General Staff is one reason the AAMC pushed for greater independence.¹⁶

¹² Holbrook, *Anzac, the Unauthorised Biography*, 46.

¹³ Butler, *The AAMS in the War of 1914-1918*, 1938, 1:v.

¹⁴ Butler, *The AAMS in the War of 1914-1918*, 1938, 1:v.

¹⁵ Butler, *The AAMS in the War of 1914-1918*, 1938, 1:vii.

¹⁶ Butler, *The AAMS in the War of 1914-1918*, 1938, 1:479.

Given the national creation myth that surrounds Australia's participation in the First World War, the relationship between Australia and Britain and its effects upon medical care is worthy of further investigation. Butler's writing routinely places the blame for problems within the Australian medical services on the British command, the Royal Army Medical Corps, and occasionally Australian government officials, whilst presenting the members of the Australian Army Medical Corps, and the AIF generally, as valiant heroes doing the best they could in spite of the conditions in which they found themselves. As an example, regarding the fighting in early May 1915 Butler writes:

The operations which took place on the 6th, 7th, and 8th gave the 2nd Australian Brigade an opportunity of showing that the Australian citizen soldier could carry through an advance under fire to the extreme limit of soldierly endurance; and to its medical personnel they provided a task, which, though not attended by heavy casualties, was as difficult as any faced by the Australian Army Medical Corps in the campaign.¹⁷

The Official History is littered with similar descriptions that emphasise the efficiency of the AAMC and the physical strength and courage of Australian soldiers. In a discussion of the merits of the Australian and British official medical histories' analyses of the Gallipoli campaign Mark Harrison concluded that "while it is rather too accepting of Australian versions of events, Butler's account stands the test of time rather better, having identified some of the key structural weaknesses which dogged medical aspects of operations on the peninsula".¹⁸ This conclusion can be carried through to other theatres of war where Butler also identifies key weaknesses and successes with the caveat that the weaknesses are invariably British and the successes Australian. This thesis re-examines much of the evidence used by Butler to discuss casualty evacuation and tests Butler's analysis to ascertain whether the Australian services were as proficient as claimed or whether there were other explanations for the successes and failures of the AAMC.

Aside from a few notable examples, since the publication of Butler's Official History there has been little written about the work of the AAMC in the First World War. Michael Tyquin's analysis of the medical services at Gallipoli in 1915 provides a critique of the work of the Australian medical services that is more nuanced than is found in Butler's official

¹⁷ Butler, *The AAMS in the War of 1914-1918*, 1938, 1:152.

¹⁸ Harrison, *The Medical War*, 172.

account.¹⁹ Tyquin examines the AAMC in the Dardanelles Campaign through official and private papers and analyses the relationships between Australian and British units. The use of private diaries, recollections, and unit diaries add a personal dimension to the work of the medical services; yet, this bottom-up approach obscures the significance of the top-down command structure of the AIF, the impact this had on the medical services, and the care its personnel provided. Tyquin argues that the system, rather than individuals, was responsible for the medical problems faced at Gallipoli and concludes that there was a distinct disadvantage for Australia in being dependent on Britain for medical and logistical provisions. Tyquin's assessment that Australia was disadvantaged by its deference to Britain is sound, though this is not necessarily the fault of Britain, with neither Australian nor British officials attempting to explicitly demarcate where one's responsibility ended and the other's began. The suggestion that the system and structure of the Mediterranean Expeditionary Force (MEF) was the cause of the failure also does not adequately represent the way the MEF functioned during the campaign. That the system failed is without doubt; however, this system was created and perpetuated, even when faced with disaster and the prospect of failure, by individuals in positions of command.

While Tyquin contradicts the ideal warrior stereotype often ascribed to Australian soldiers, he still holds to the national identity myth present in Australian military history. In his book about Gallipoli, Tyquin concludes:

It was out of the brutal tragedy of Anzac that a tradition of medical care and organisation was born, a tradition which began to utilise many uniquely Australian qualities. The Australian medical services came out of the Gallipoli campaign sobered by its experiences, having served its sick and wounded admirably.²⁰

Tyquin's reference to Australian exceptionalism reinforces the myth that Australia's national identity was formed during the campaign, and his treatment of Gallipoli as an isolated case obscures the significance of the Dardanelles Campaign to the future functioning of the medical services. In contrast, this thesis draws a direct line from the lessons learnt in the Dardanelles Campaign to the work of the AAMC on the Western Front.

¹⁹ Michael B. Tyquin, *Gallipoli: The Medical War: The Australian Army Medical Services in the Dardanelles Campaign of 1915* (Sydney: NSW University Press, 1993).

²⁰ Tyquin, *Gallipoli*, 199.

Further histories of the AAMC in the First World War include expressions of this national founding myth, which was itself a response to discomfort with the imperial hierarchy that gave precedence to British endeavours and agency. These histories have largely focussed on individuals within the campaign, creating heroic figures of national pride, including a number of biographies of Neville Howse, who eventually became Director of Medical Services (DMS) for the AIF.²¹ As already mentioned, vast reams of paper have also been dedicated to the exploits of John Simpson Kirkpatrick, ‘the man with the donkey’.²² As a result of biography being a primary form of history in this field, the general understanding of the work of the AAMC in the First World War has been constructed through the example of the most senior member of the corps or the mythic figure of a man with an indefatigable ass. Simpson’s story has become the embodiment of Australian medicine at Gallipoli yet his efforts at Gallipoli were not conspicuous. Rather, they were emblematic of the work of the men in the Australian Field Ambulance. Moreover, given that Simpson was killed in May 1915, in one of Australia’s first military campaigns of a protracted war, using his military service as a vehicle for understanding the work of the AAMC is a flawed approach. In *Dust Donkeys and Delusions: The Myth of Simpson and his Donkey Exposed*, Graham Wilson acknowledges the limitations of the existing historiography and attempts to actively dismantle the mythology constructed in the past 100 years.²³ Whilst this is a valuable contribution to the field, the piecemeal approach of debunking a collection of myths fails to fully inform the reader, who is told what did not happen rather than what did.

Military and Medical Hierarchies

Adherence to military hierarchy was routine during the war and it was through this system of command that medical arrangements were made for Australian soldiers. Historians have assessed the planning and execution of these arrangements as indicators of the effective functioning of the military hierarchy. Butler’s history is detailed in its descriptions of the plans put in place for casualty evacuation and how effectively the units concerned were deployed. As a Commanding Officer of an Australian Field Ambulance in the early part of

²¹ Stuart Braga, *ANZAC Doctor: The Life of Sir Neville Howse, Australia’s First VC* (Sydney: Hale & Iremonger, 2000); Michael B. Tyquin, *Neville Howse: Australia’s First Victoria Cross Winner* (Melbourne: Oxford University Press, 1999); Wales Murdoch, *Neville Howse VC: Soldier, Surgeon & Citizen: A Biography of Major-General Sir Neville Howse VC, KCB, KCMG, KStJ* (Brisbane: Amphion Press, 1997).

²² Benson, *The Man with the Donkey*; Cochrane, *Simpson and the Donkey*; Curran, *Across the Bar*.

²³ Wilson, *Dust Donkeys and Delusions*.

the war, Butler was well aware that plans for casualty evacuation were not always implemented as intended. Butler also assesses the overall success of the medical services and describes the changes that were made to the internal structures of the medical services. His dense descriptions are supported and clarified by numerous maps and photographs; however, his footsteps are difficult to trace in the archives due to the referencing conventions used.

Placing a greater emphasis on military over imperial hierarchies than Butler or Tyquin, Mark Harrison examined the work of the British medical services of the First World War. In *The Medical War: British Military Medicine in the First World War*, Harrison agreed with Tyquin stating:

the breakdown of medical arrangements in Gallipoli was symptomatic of the Army's difficulties in coming to terms with the realities of modern warfare. The command structure of the Gallipoli campaign resembled that of a small colonial expedition in which traditional hierarchies worked to the detriment of professional expertise.²⁴

Harrison argues that a more consultative command structure had existed on the Western Front, before the commencement of the campaign in the Mediterranean, demonstrating that it was possible for the medical services to be integrated into the planning and prosecution of combat operations. This suggests that a greater emphasis on the personnel involved is warranted. It also suggests that it is worth investigating how the AAMC worked under these two different cultures of command. Accordingly, this thesis locates Australia's participation in the Dardanelles Campaign within the broader context of the First World War and directly relates it to action on the Western Front, the main theatre of war. Thereby it provides a clearer picture of how the Dardanelles Campaign informed the way the AAMC interacted with the British medical services on the Western Front from 1916.

This thesis argues that the involvement of civilians in providing care to Australian soldiers disrupted military dominance and altered the nature of the medical-military spaces in which the AAMC cared for sick and wounded men. As will be discussed in Chapter 4, the AAMC relied not only on civilian doctors in military uniform but also on civilian women in paid and voluntary work in hospitals for wounded Australian soldiers recovering in Britain. The British public was invested in the medical care of its soldiers during the First World War and Mark Harrison links the involvement of civilians in wartime caregiving to

²⁴ Harrison, *The Medical War*, 203.

soldiers' rights. He argues those rights posed a significant political problem in Britain suggesting that a growing acknowledgement by the general public that soldiers were fighting on their behalf resulted in a push for better recognition for those returned from duty.²⁵ The voluntary involvement of British civilians in Australian military hospitals caring for men a vast distance from their kith and kin extended this humanitarian effort across the imperial network. Harrison suggests that the idea of a social contract between the state and the soldier gained momentum after the Boer War and was important in the First World War. He states that by the end of the nineteenth century:

servicemen were beginning to demand health care as a right, and to regard it as a kind of 'social wage' earned in the service of their country. They appealed not only to the paternalistic and humanitarian inclinations of certain sections of the community but also to modern concepts of citizenship and social justice.²⁶

This 'social wage' was earned by Australian soldiers not just in service to their country but also in service to empire. I argue that while British involvement in Australian medical care was reduced and sometimes resented, this did not trickle down from the institutional or organisational level. Instead, the efforts of civilian British women in Australian auxiliary hospitals extended beyond their professional capacities to the personal and the resulting relationships between people in these spaces suggest there were limits to Australians' distrust of British interventions.

Viewing medicine and the military more as competing priorities, rather than hierarchies that act on each other, previous histories of medicine in war have attempted to reconcile military and medical concerns. In their discussion of the intersection of war, medicine and modernity, Roger Cooter and Steve Sturdy argue that the First World War marked a new phase in the development of military medicine. They describe it as:

a crucial site for the development of new kinds of medical organization and division of labour. Medicine was no longer simply an ancillary discipline to warfare, concerned merely with patching up the bodies of the injured. By the war's end it had become a key site for pursuing the kinds of technical and

²⁵ Mark Harrison, "Medicine and the Management of Modern Warfare: An Introduction," in *Medicine and Modern Warfare*, ed. Roger Cooter, Mark Harrison, and Steve Sturdy (Atlanta: Editions Rodopi B. V., 2004), 3–4.

²⁶ Harrison, "Medicine and the Management of Modern Warfare: An Introduction," 4.

administrative innovations that were now increasingly seen as crucial for the prosecution of modern warfare.²⁷

The integration of medical care as central to warfare placed the State in control of men's bodies and introduced a third party to the doctor-patient relationship. In her doctoral thesis on the British medical profession in the First World War Marya Schock suggests:

The war threw into relief the deep ethical conflicts which doctoring under the aegis of an all-powerful third party entailed. Participants in the Great War required that doctors determine whether they could simultaneously heal the patient and serve the state.²⁸

These ideas were explored further by Ana Carden-Coyne in *The Politics of Wounds: Military Patients and Medical Power in the First World War*.²⁹ Focussing mainly on British men, with reference to Dominion and American soldiers, Carden-Coyne prioritises patients' perspectives and locates the wounded citizen soldier's personal experience and articulation of pain in the "political realm".³⁰ Carden-Coyne discusses the introduction of a third set of priorities, that of the state, and suggests that through a political network of the state, the military and medical practice "[t]he military subordinated individual will with its hierarchical structures, through its training techniques and its disciplinary regime."³¹ According to Carden-Coyne, military patients viewed medical practitioners (including doctors, nurses and physiotherapists) as part of the "war machine" and party to patients' 'brutalization' and disempowerment.³² This thesis accepts Carden-Coyne and Joanna Bourke's findings that medical officers exerted power and authority over soldiers' bodies and argues that, due to the differing priorities of the various actors at each site of care, authority over soldiers' bodies was distinctly expressed in each form of medical care discussed.³³ This thesis also argues that the disempowerment of which Carden-Coyne writes was not consistent across the different forms of care, with the education and active involvement of soldiers

²⁷ Roger Cooter and Steve Sturdy, "Of War, Medicine and Modernity: An Introduction," in *War, Medicine and Modernity*, ed. Roger Cooter, Mark Harrison, and Steve Sturdy (Stroud: Sutton, 1999), 12.

²⁸ Marya Schock, "Healing the Patient, Serving the State: Medical Ethics and the British Medical Profession in the Great War" (PhD Thesis, University of California, Berkeley, 2000), 9.

²⁹ Ana Carden-Coyne, *The Politics of Wounds: Military Patients and Medical Power in the First World War* (Oxford: Oxford University Press, 2014).

³⁰ Carden-Coyne, *The Politics of Wounds*, 3.

³¹ Carden-Coyne, *The Politics of Wounds*, 3.

³² Carden-Coyne, *The Politics of Wounds*, 338.

³³ Joanna Bourke, *Dismembering the Male: Men's Bodies, Britain and the Great War* (London: Reaktion Books, 1996).

becoming essential in the AAMC's attempts to combat the effects of venereal disease on the AIF.

Gender Hierarchy

The analysis of medical authority over soldiers' bodies has led to the examination of gender in the historiography of medical care in First World War. Joanna Bourke's seminal *Dismembering the Male: Men's Bodies, Britain and the Great War* examined the effects of the war on masculinity and the male body including discussions of wounding and bodily inspection.³⁴ Bourke links the wounded male body with shifting understandings of masculinity and the effects on the men, their families, and their communities. She emphasises continuity over change in the increasing importance of heterosexual domesticity to masculine maturity during and after the war. Bourke does not differentiate between scholarly examination of the male body and the study of masculinity and argues that the war acted as a catalyst for already existing moves toward disciplining bodies. She demonstrates the routine scrutiny, categorisation and regulation of male bodies and she suggests that almost all young adult and middle-aged men in Britain would have had their bodies inspected and assessed during the war.³⁵ Despite the different context in Australia, where attempts to introduce conscription failed, the majority of men of fighting age would have been inspected. The men at the younger end of this age spectrum were the same men who, as boys, were subject to inspection by the State whilst at school.³⁶ In Chapter 5, about the efforts to prevent venereal disease, I suggest that the normality of bodily surveillance by the state was one of the factors that enabled routine genital inspections to take place, with little opposition, in the AIF in order to limit the impact of venereal disease.

Joanna Bourke's focus on the male body in war was continued and expanded upon by Ana Carden-Coyne who located the military patient in a "web of intimate social encounters and institutionalized relationships focusing particularly on the way power operates in the fraught negotiations that occur around wounded men's bodies".³⁷ She suggests that the gender hierarchy was inverted in some instances with women, in the roles of nurse or physiotherapist, able to inflict pain on men's bodies. This combined with the

³⁴ Bourke, *Dismembering the Male*.

³⁵ Bourke, *Dismembering the Male*, 172.

³⁶ F. B. Smith, "Medical Inspection of State Schoolchildren in Australia, C. 1905-14," *Health and History* 10, no. 1 (January 1, 2008): 5-20.

³⁷ Carden-Coyne, *The Politics of Wounds*, 9.

crisis in masculinity (as a consequence of the emasculating effects of wounding) to require men to regain their manhood by transitioning through a feminised state. She writes:

Therapies were framed on gendered lines. Before regaining the masculine grip of bayonets or guns, the patients learned to hand-stitch delicate material and knit woollen items, practices that were associated with women, such as sock-knitting for soldiers.³⁸

While I agree, in Chapter 4, that therapies were framed on gendered lines, I am not convinced that men were required to pass through a transitory, rehabilitative feminised state in the gender hierarchy between wounded asexual being and masculine warrior. Rather, I argue that the rehabilitation activities available to men in auxiliary hospitals were expressions of the gendered nature of the work and workers rather than the patients. In Chapter 5, I also argue that gender did not just shape the way different forms of care were provided but that gender norms were actively harnessed in the attempts to combat venereal disease.

This thesis is the result of extensive archival research drawing mostly on the collections of the Australian War Memorial (AWM) and the National Archives of Australia. Army orders, unit war diaries, and memoranda written to disseminate information within the AIF and between British and Australian officers form the majority of the source base. The statistical records kept by medical officers have also been used, especially in my analysis of the response to venereal disease. The war diaries of Australian units are particularly useful. While they were written to record events after they had occurred, and therefore had the potential to be used to justify decisions made or diminish mistakes, they were subject to review by John Treloar, Officer-in-Charge of the Australia War Records Service. He provided feedback to unit commanders on the quality of their reports and insisted upon the correct naming of units, precise references to dates, locations, units and times, and the accurate use of map references.³⁹ He also introduced standardised stationery to encourage uniformity in reporting and, according to Condé, he made officers aware that their words “were not placed in some ‘dusty corner’ at Base and promptly forgotten [but] would form an ‘accurate record’ on which the history of the war would be written”.⁴⁰ As a

³⁸ Carden-Coyne, *The Politics of Wounds*, 266.

³⁹ Anne-Marie Condé, “Imagining a Collection: Creating Australia’s Records of War,” *reCollections: Journal of the National Museum of Australia* 2, no. 1 (2007): 28.

⁴⁰ Condé, “Imagining a Collection,” 28.

result, the Australian unit war diaries provide detailed descriptions of events and numerous useful appendices that illustrate the work of the AIF.

Private papers supplement these official papers in order to provide necessary contextual information and demonstrate the unofficial work done by military men in the course of their duties. These personal papers demonstrate commanders' decision-making and the ideas that underpinned their approaches to medicine in war outside of bureaucratic processes. Neville Howse's papers at the AWM are used, as are the personal papers of Sir Ian Hamilton from the Hamilton Collection housed in the Liddell Hart Centre for Military Archives at King's College London, and those of Earl Haig from the Haig Papers at the National Library of Scotland.

Also in the collection of the AWM is the full catalogue of *The Harefield Park Boomerang*, the hospital magazine of the First Australian Auxiliary Hospital, Harefield Park.⁴¹ Hospital magazines were a form of mental and physical care practised in hospitals and are one genre of non-canonical wartime literature.⁴² In his advocacy for the use of hospital magazines as sources of patient resistance, Jeffrey Reznick writes: "As this official literature helped authorities to sharpen their own vision of the hospital it was intended to – and did – allow recovering soldiers to express their frustration with the institution."⁴³ Ana Carden-Coyne highlights the cultural life within medical spaces stating that: "patients used wit, irony, and gallows humour to negotiate power relations, as a mode of resistance, and to manage systemic tensions".⁴⁴ *The Harefield Park Boomerang* was published from late 1916 through to the victory edition in December 1918 and is used in Chapter 4 to illuminate the interaction between staff and patients. It also furthers the discussion of rehabilitative medical care and the context in which it was practiced. The magazine is not just a vehicle for understanding patient voices, as a sanctioned form of care it was another method of rehabilitating the soldier.

Further British archives were used to demonstrate the relationships between British and Australian institutions and organisations. The papers of the National Council for

⁴¹ *The Harefield Park Boomerang* (hereafter *The Boomerang*) 1, no. 1, (December 1916) – 2, no. 11, (December 1918), Australian War Memorial: AWM081392 TROOPSHIP SERIAL/The Harefield Park Boomerang.

⁴² Jeffrey S. Reznick, *Healing the Nation: Soldiers and the Culture of Caregiving in Britain during the Great War* (Manchester: Manchester University Press, 2004), 68.

⁴³ Reznick, *Healing the Nation*, 65.

⁴⁴ Carden-Coyne, *The Politics of Wounds*, 12.

Combating Venereal Disease, held at the Wellcome Collection in London, provide context for the AIF's attempts to curtail the rate of venereal disease among its soldiers stationed in the United Kingdom. These papers include sample lectures and information that was disseminated to British servicemen and highlight the transfer of ideas between British and Australian groups grappling with this problem. The discussion of the problems at Gallipoli makes significant use of the Dardanelles Commission files from The National Archives. The transcripts of evidence and the submissions to the Commission show the politics involved in the imperial hierarchy as many in command sought to shift blame for the failures of the Allied forces in the Dardanelles.

This thesis does not delve in to the work of the AAMC where it was not primarily in control of sick and wounded Australian soldiers. Casualty Clearing Stations (CCSs) were not necessarily allocated to Australian sectors therefore, at the CCS, Australian casualty evacuation lines merged with those of the British Expeditionary Force. While they did treat many Australians it was not automatic that a sick or wounded soldier would be sent to an Australian General Hospital or an Australian Base Hospital. Once evacuated to England those requiring further treatment were treated in British hospitals before being sent to Australian Auxiliary Hospitals. Accordingly, this thesis examines the work of the AAMC between the trench and the CCS and then in England in auxiliary hospitals. An analysis of the response to venereal disease is included as it was a significant problem that the AAMC was directly responsible for curtailing within the Australian Imperial Force.

As the casualty clearance chain between the Western Front and England form the focus of this thesis, and Gallipoli is included as it directly influenced work in that sphere, the work of the Australian Medical Officers in the Middle East has been excluded from this analysis. This, however, could provide a robust case for comparison in future studies. I have also excluded the work of the AAMC in the Pacific as the Australian Naval and Military Expeditionary Force sustained few injuries and had little impact on the development of Australian Medicine on the Western Front. This thesis also does not discuss the work of nurses in detail. In France, Australian nurses worked as far forward as CCSs and no further, placing their work outside of the area under the most scrutiny. Their work in auxiliary hospitals is discussed in the relevant chapter alongside a discussion of the gendering of the work in those spaces, including the work of physiotherapists and civilian labour.

Chapter One

“Criminal negligence”: Medical Arrangements for Australians at Gallipoli

Whilst giving evidence under oath to the Dardanelles Commission in 1917, Surgeon General Sir Neville Howse, Director of Medical Services (DMS) for the Australian Imperial Force (AIF), stated that the medical arrangements for the Gallipoli campaign “as far as the Australian troops were concerned, were so inadequate that they amounted to criminal negligence”.¹ He laid blame for this on the British General Staff and told the Commission he intended to share his concerns with Australia’s leaders, saying: “I personally will recommend my Government when this war is over, that under no conceivable conditions ought they ever to trust to the medical arrangements that may be made by Imperial authorities for the care of their sick and wounded.”² These statements are indicative of the rest of Howse’s evidence to the Commission and demonstrate his frustration with the way the medical services were organised for the Dardanelles Campaign. Howse’s scathing critique not only called into question the British General Staff’s ability to plan and execute a comprehensive strategy but it also revealed his doubt in the benefits of Australian deference to Britain in medical-military matters.

The Mediterranean Expeditionary Force (MEF), an international force led by Britain with troops also from France, India, Newfoundland, New Zealand, and Australia, undertook the Dardanelles Campaign. In the Campaign, authority over the planning for medical provisions and the medical evacuation of casualties lay with the British General Staff. The medical services, including those from Britain, were excluded from strategic and tactical preparations and had limited influence over the plans for the landings in April 1915 or the August Offensive later the same year. As a result, the most senior member of the Australian Army Medical Corps (AAMC) in the MEF was far removed from the decision-making process and, despite perceiving the substantial problems with the medical plans, was unable to remedy them from his position. The AAMC was subordinate to its British equivalent creating a situation where Australian soldiers were under the British General Staff’s control for medical issues. Thus, Australians had little opportunity to make decisions

¹ Surgeon General Sir NR Howse, Evidence to Dardanelles Commission (hereafter DC) q. 27667, The National Archives, UK (henceforth TNA): CAB 19/33.

² Surgeon General Sir NR Howse, Evidence to DC q. 27675, TNA: CAB 19/33.

about medical arrangements affecting Australian soldiers in the campaign and had limited control of medical care beyond the Divisional level.

In this chapter I agree with Mark Harrison's assessment of the Dardanelles Campaign, that "traditional hierarchies worked to the detriment of professional expertise", but whereas he focuses on the British forces, I focus on the AAMC and its interaction with the rest of the MEF.³ This chapter examines the planning, prosecution and aftermath of the Dardanelles Campaign and traces the changing location of medical control and responsibility during the campaign. It outlines the different expectations the British and Australian medical services had of their respective roles and relationship, as well as demonstrating that Australian doctors' abilities to make decisions about Australian soldiers' medical care were hampered by their country's position as a Dominion force subservient to imperial authorities. I argue that these factors combined to necessitate the development of an independent, self-governing AAMC – one able to draw on its own personnel and resources for expertise and material – that controlled medical issues for the AIF.

The Preamble: Organising the Force

Australia's involvement in the army medical services of the British and Dominion forces was poorly defined at the beginning of the First World War. Initially Australia provided the Divisional-level medical services required to support the troops supplied. Australia, however, did not supply line-of-communication or base units to treat casualties evacuated from their units or to train the recovered soldier before returning him to the front. These units were supplied by Britain; Australian casualties were to filter through the British lines to British bases. When Australia was asked to provide some units for these purposes there was no clear delineation of British and Australian responsibilities. Butler described the nebulous nature of this relationship:

The position apparently was that anything that the Commonwealth contributed was welcome - Great Britain would make good the rest. This absence of definition of the obligations of Australia in the matter of medical arrangements was unfortunate, for sentiment, however generous and reciprocal, cannot take the place of a clear, business-like understanding.⁴

³ Mark Harrison, *The Medical War: British Military Medicine in the First World War* (Oxford: Oxford University Press, 2010), 203.

⁴ Arthur G. Butler, *The Australian Army Medical Services in the War of 1914-1918: Gallipoli, Palestine and New Guinea*, vol. 1 (Melbourne: Australian War Memorial, 1938), 86–7.

This failure to delineate responsibilities caused problems for the Director of Medical Services for the Australian Imperial Force. Surgeon General William 'Mo' Williams was limited in his capacity to act by the ill-defined nature of responsibility for medical care. Originally based in the War Office in London under the British Director General of Army Medical Services, Sir Alfred Keogh, Williams also liaised with the Australian High Commissioner to London, former Australian Prime Minister Sir George Reid.

Despite being the main architect of the Australian Army Medical Corps and one of only four regular officers in the corps, Williams struggled to define his role and responsibilities. He left Australia as part of the first convoy and then continued on to England. When in England he spent time requisitioning official and Red Cross medical stores and organising and equipping a system of convalescence and rehabilitation for Australian soldiers evacuated to England. Once it became clear that the Australian forces would be deployed from Egypt to the Mediterranean, Williams went to Egypt to make arrangements for the AAMC units across all levels of command. Because of the failure to demarcate Australian and British responsibilities Williams lacked the authority to command the medical forces. There already existed a British Director of Medical Services for both the Force in Egypt, which would function as the base, and for the Mediterranean Expeditionary Force, responsible for medical arrangements at Divisional level and along the Lines of Communication. Neither of these men recognised Williams' authority to command Australian troops who had already been placed under their leadership leaving Williams in the unenviable position of having rank and position without authority.

The British General Staff of the MEF drew up the medical arrangements for the Gallipoli Landings and excluded the medical services from this process. 'Force Order No. 1' was issued for the MEF on 13 April 1915 and the complete instructions under the heading 'Medical' read: "Casualty Clearing stations will be located on Beaches 'W' and 'Z' by the afternoon of the first day. Men and animals unfit for duty on the day of disembarkation will remain on their transports."⁵ These arrangements were expanded and elaborated upon over the following days. The original estimate by Sir Ian Hamilton, General Officer Commanding (GOC) the MEF, was for 3000 casualties for the landing phase of the campaign for the entire peninsula.⁶ As of 18 April there were two hospital

⁵ 'Force Order No. 1', General Staff, GHQ, MEF, War Diary 13 April 1915, Australian War Memorial (hereafter AWM): AWM4 1/4/1 PART 2.

⁶ Lieutenant Colonel AEC Keble, Statement to DC, TNA: CAB 19/29.

ships, *Sicilia* and *Gascon*, available for use, which could accommodate a total of 700 serious cases for evacuation. Brigadier General Woodward, the British Deputy Adjutant General (DAG) for the MEF, wrote to Braithwaite, the Chief of the General Staff (CGS), and the Quartermaster General (QMG), with concerns about these arrangements, stating: “In the event of serious fighting these two ships will not provide sufficient accommodation for evacuating wounded men from the shore.”⁷ He believed the arrangements to be so inadequate that he asked permission to requisition nine further ships for casualty evacuation.⁸ As DAG, Woodward was responsible for drafts and reinforcements so needed to know the expected number of casualties and the proposed method of evacuation in order to plan for their replacement with new troops. The following day Woodward again wrote to Braithwaite and outlined the medical arrangements he had made so far, reiterating the inadequacy of the provision of hospital ships as well as the insufficient number of launches to get casualties from the beach to the ships.⁹ At this point the intended date for the commencement of the landings was four days away and no one from the medical services had been involved in the planning of medical arrangements.

Meanwhile, the British DMS MEF, Surgeon General Birrell, was still in Alexandria and unable to participate in the planning.¹⁰ His deputy, Lieutenant Colonel Alfred Ernest Conquer Keble of the RAMC, the highest ranking medical officer in the vicinity of the General Staff, attempted to find out what plans were being made but was rebuffed and prevented from voicing his dissent regarding the medical arrangements. He had found out, through unofficial channels, about the plans mentioned above and felt that they were inadequate and should be the responsibility of the medical services not the General Staff. When later questioned about his actions at this time, he wrote:

I wrote to Surgeon-General Birrell in Egypt and informed him of my inability to get into touch with the General Staff and suggested that he should come up as quickly as possible. I saw various Junior members of the General Staff and finally one of them – I think Colonel Ward – informed me that he had drawn

⁷ Brigadier General EM Woodward to CGS & QMG, General Staff, GHQ, MEF, War Diary 18 April 1915, AWM: AWM4 1/4/1 PART2.

⁸ Brigadier General EM Woodward to CGS & QMG, General Staff, GHQ, MEF, War Diary, 18 April 1915, AWM: AWM4 1/4/1 PART2.

⁹ Brigadier General EM Woodward to CGS, General Staff, GHQ, MEF, War Diary, 19/4/1915, AWM: AWM4 1/4/1 PART2.

¹⁰ Surgeon General WG Birrell, DMS MEF War Diary, 1-24 April 1915, AWM: AWM4 26/3/1. Accounts differ as to whether Birrell was unwell or attending to his duties regarding the organisation of hospitals in Egypt or some combination of the two.

up a scheme for the medical arrangements. I told him that was no business of his and I refused to have anything to do with that scheme. He then asked me to make my own scheme, which I said was my job and I was quite able to do it if he would give me the estimated casualties as a basis. He told me he would get this information from the CGS. Later I saw him and he informed me that the estimated casualties would be 3,000. I laughed at this and said that as I had to make the scheme I would prepare for 10,000, and my preparations for 10,000 would probably cover 20,000 because the ships would have time to return from Egypt and so would be able to cope with the casualties.¹¹

At this point Keble drew up his own plan; it was the first to take into account the possibility of outright defeat but still did not allow for the possibility that the invading armies might be able to gain a foothold on the beach without proceeding inland to meet their objectives.¹² Once Birrell arrived in the area he approved Keble's plans, which were subsequently approved by Woodward, then Hamilton, without further alteration. This was too late for many of the resources and personnel to be available in the area by 25 April and consequently the medical services were not at full strength for the landing.¹³

Given the RAMC's lack of involvement in the medical arrangements up to this point it is not surprising that their AAMC counterparts were also restless and concerned by the plans. Not satisfied with the state of the medical arrangements, the Assistant Director of Medical Services (ADMS) for the 1st Australian Division, Colonel Neville Howse, implied to the GOC 1st Australian Division, General Bridges, that Bridges might have responsibilities beyond those that his rank and position conferred upon him. Howse suggested that Australia would hold Bridges responsible for the medical arrangements for the Australian troops he was commanding during the landings. When Bridges responded by saying: "That has nothing to do with the Officer Commanding a Division", Howse pushed him further asking "Do you give that as an official reply?"¹⁴ As a result of this conversation Howse and Bridges went to see General William Birdwood, GOC of the Australian and New Zealand Army Corps (ANZAC), to find out what medical arrangements had been made for Australian troops at the Corps level. Birdwood responded: "As Corps Commander I have nothing whatever to do with the medical

¹¹ Lieutenant Colonel AEC Keble, Statement to DC, TNA: CAB 19/29.

¹² Lieutenant Colonel AEC Keble, Statement to DC, TNA: CAB 19/29.

¹³ Lieutenant Colonel AEC Keble, Statement to DC, TNA: CAB 19/29.

¹⁴ Surgeon General Sir NR Howse, Evidence to DC q. 27664, TNA: CAB 19/33.

arrangements for landing my troops, but I see it is absolutely essential that we should have some information.”¹⁵ With these conversations occurring as late as 20 April, only days before the landings, it appears as though the official historian of the Australian medical services was correct when he mused that “the medical problems of the Australian force were not the recognised business of anyone in particular”.¹⁶

Confusion reigned in the medical services even before the campaign commenced. On 22 April Howse received orders that all Australian men unable to proceed to the peninsula must be returned to the 1st Australian Stationary Hospital on the island of Lemnos (1ASH Lemnos). Howse duly instructed Medical Officers to send all their cases from the transports; however, the Officer Commanding 1ASH Lemnos returned the men to the transports as he had instructions from the DMS MEF that he was not to take any further cases.¹⁷ That same day Howse visited Birrell to discuss the medical arrangements for the Australian troops at Gallipoli. They discussed the insufficient provision of ships and transports to evacuate Australian casualties as well as the problem of keeping infectious cases, especially measles, on-board transports prior to the landing. Birrell responded to Howse that the infectious cases should be isolated onboard their current ships, that no further cases could be sent to 1ASH Lemnos as it was full and could not be expanded further, and that instructions for the evacuation of wounded had been sent to the ANZAC headquarters.¹⁸ The following day, 23 April, Howse asked General Carruthers, Deputy Adjutant and Quartermaster General (DAQMG) ANZAC, about any arrangements that had been made for evacuating the wounded. Howse wrote in his war diary:

He stated that no further news had been received. I strongly urged upon him the absolute necessity of getting definite instructions before we landed against the enemy. No transports had been prepared and only two Transports had been allotted any Staff. He stated that I would receive definite instructions before we landed.¹⁹

That evening Howse was transported onto HMS *Prince of Wales* and there he remained until the landing. He sailed from Lemnos to the area that would become known as Anzac Cove,

¹⁵ Surgeon General Sir NR Howse, Evidence to DC q. 27664, TNA: CAB 19/33.

¹⁶ Butler, *The AAMS in the War of 1914-1918*, 1938, 1:102.

¹⁷ Colonel NR Howse, ADMS 1st Australian Division, War Diary 22 April 1915, AWM: AWM4 26/18/5.

¹⁸ Colonel NR Howse, ADMS 1st Australian Division, War Diary 22 April 1915, AWM: AWM4 26/18/5.

¹⁹ Colonel NR Howse, ADMS 1st Australian Division, War Diary 23 April 1915, AWM: AWM4 26/18/5.

arriving early on 24 April, and landed on the beach at 7:22am on 25 April 1915.²⁰ There is no record in Howse's War Diary that he ever received the 'definite instructions' Carruthers assured him would be forthcoming before the landing.

Gallipoli: The April Landings and August Offensive

The landings took place in the early hours of 25 April 1915. While some units were able to reach their objectives many were not and the gains that were made were not consolidated. The Turkish troops counterattacked that afternoon and at the end of the day the ANZAC troops had established a beachhead but were unable to advance further inland due to the terrain and the opposition of the Ottoman Turks. The ANZAC forces then dug in and formed a series of trenches leading back to the beach. The fighting continued on subsequent days, however, the foothold on the peninsula, gained by ANZAC, was not substantially increased.²¹

The lack of foresight in the medical arrangements had dire consequences once the plans were put into action and the landings on the Gallipoli peninsula commenced. If the MEF had been able to meet its objectives and advance inland there would have been a better outcome for the casualties. The plans that had been made required significant medical infrastructure on the peninsula and casualties were supposed to be sorted before being loaded into ships for evacuation to the base. This would have meant that soldiers with minor injuries, who would have been ready to return to service within three or four days, would not leave the area. Due to the failure to advance inland the full complement of medical services was unable to land on the peninsula and the medical arrangements then had to be improvised.

The inability to land was not confined to the medical services; not all of the troops were able to go ashore as planned and this resulted in ships that were already full of soldiers then trying to take on board and provide medical care to casualties. The medical services that were established on the beach were also insufficient to manage the casualties. The 1st Australian Casualty Clearing Station (1ACCS) and staff were landed a few hours after the first wave of troops and set up on the beach. This required cutting into the cliff

²⁰ Colonel NR Howse, ADMS 1st Australian Division, War Diary 25 April 1915, AWM: AWM4 26/18/5.

²¹ For further details on the operational aspects of the landings from a medical viewpoint see Harrison, *The Medical War*; Tyquin, *Gallipoli*; Butler, *The AAMS in the War of 1914-1918*, 1938.

face to create enough space to erect the tents.²² As there was no shelter from the cliffs above, the Casualty Clearing Station was visible and susceptible to shrapnel; however, the Ottoman army did respect the Red Cross markings and did not fire directly on the medical services. Given that this was an amphibious landing, unprecedented in scale, a great deal of coordination was needed between the army and the navy in order to get casualties from the beach to the hospital ships. The RAMC was responsible for casualties on land until such time as they were placed on a transport. These transports were under the jurisdiction of the navy and the navy had responsibility for casualties from the water's edge until the casualty was loaded onto a hospital ship. Despite being a ship, the hospital ships, as well as the transports used from this point on (known as 'black ships'), were often staffed by the RAMC and AAMC but operated by the Royal Navy. The failure to advance inland also meant that there was a greater demand upon the already limited number of hospital ships. As some of the hospital ships had not arrived at the commencement of the landings, and communication was limited, the disposal of wounded soldiers onto ships was haphazard.

The changes in responsibility between army and navy were exacerbated by the poor communication possible between branches of the armed forces and between individual ships. The navy reported that once soldiers were embarked onto barges it had problems finding ships that were able to take on casualties. Some of these barges worked their way around many of the ships in the area being rejected by one after another. The lack of communication meant that some ships sailed before they were full and without notifying headquarters. Howse later told the Dardanelles Commission that the unprecedented nature of the landings was part of the problem, stating:

I do not think the arrangements were adequate and I do not think that there was any cohesion between the Army and the Navy. I repeatedly made inquiries whether any consultation with the Medical Staff and the Navy and Army took place before our landing, as I had no record of such having taken place, and we were in the unfortunate position of having no history to guide us of a previous landing on such a big scale.²³

Lord Nicholson's line of questioning at the Dardanelles Commission suggests he was suspicious of the level of communication between the medical services and the Royal Navy. He asked Lieutenant Colonel John Corbin, an AAMC Officer from 1ACCS, "But

²² Colonel NR Howse, ADMS 1st Australian Division, War Diary 25 April 1915, AWM: AWM4 26/18/5.

²³ Surgeon General Sir NR Howse, Evidence to DC q. 27675, TNA: CAB 19/33.

Colonel Keeble [*sic*] does not communicate with the Navy does he?”²⁴ Given the interconnected nature of the campaign it is surprising that there was not better communication between the various services. Whilst the General Staff was on the *Queen Elizabeth*, Birrell, the Director of Medical Services, and the rest of the Administrative Staff were located on the *Arcadian* and were unable to communicate with GHQ during the landings.²⁵ This effectively cut off the medical services from handling the medical evacuation of casualties.

With many casualties accommodated on ships that were not properly fitted out for those seriously wounded, and there being a significant period of time between wounding and treatment, many soldiers suffered increased pain and unnecessary difficulty. Some ships had been used to carry animals including horses and donkeys to the peninsula; these ships had to be used to take on casualties without adequate time to equip them or clean them sufficiently well to have them function as hospital ships. In at least one instance the horses remained on the ship along with the casualties. In his evidence to the Commission, Lieutenant Colonel Charles Ryan, the consulting surgeon to the Australian and New Zealand Forces at Anzac, suggested the horses caused problems for patients:

I think there had been about 200 horses on board her for six weeks, and the result was that they were kicking and screaming, and making a great noise all night, with the consequent result that a lot of the poor unfortunate fellows were driven distracted with the noise. You can imagine what it is to be in a considerable amount of pain, and to hear horses screaming and kicking.²⁶

The resulting exposure to infection was a significant problem for casualties with open wounds. Ryan continued in his evidence, stating:

But you see the trouble was that we had to do very serious operations under great difficulties. A man, say, was shot through the abdomen, and his bowels were perforated, and the only chance of his recovering was an immediate operation. Now there were two things necessary: one was that too long a time should not elapse between the injury and the operation, and the other was that you had to take every possible antiseptic precaution. But on these boats we could not do that, there were no means of sterilizing instruments, or procuring

²⁴ Lieutenant Colonel J Corbin, Evidence to DC q. 28610, TNA: CAB 19/33.

²⁵ 'Final Report of the Dardanelles Commission', 1919, paragraph 164, TNA: CAB 19/33.

²⁶ Lieutenant Colonel C Ryan, Evidence to DC q. 28697, TNA: CAB 19/33.

proper dressings or anything else... [W]ith regard to head injuries, there were a great number of men who were shot in the head, and it was necessary that everything for their treatment should be as antiseptic as possible, but under the conditions there, it was absolutely impossible. We had so much to do that we simply could not do it.²⁷

Along with this evidence, Ryan gave the Commission examples of ships being ill-equipped for casualties with one ship, carrying 700 wounded soldiers, being without a single bed pan. In addition to this, no ships were staffed with nurses and there were only three medical officers and a surgeon for a ship with 800 casualties.²⁸

In response to the failure of the medical services to adequately manage the casualties from the April Landings, Britain made significant structural and personnel changes. These were put in place to alter the way the medical services functioned and to better delineate lines of responsibility and reporting. The changes were made from June 1915, once it became clear that a new strategy would be needed in order to salvage the campaign and enable the MEF to meet its objectives. However, those changes muddled the waters further, and it was still not clear how medical responsibility was divided. In an attempt at remedying the problems caused by the army and navy both having responsibilities in this space, and acknowledging that the number, organisation, and loading of hospital ships was a weakness in the plans for the landings, Sir James Porter was made Principal Hospital Transport Officer (PHTO) by the Royal Navy. The RAMC then appointed Surgeon General William Babbie to the newly created position of Principal Director of the Medical Services (PDMS) for the MEF. These men did not have their responsibilities or scope satisfactorily outlined and they were found to be very much replicating the same role. Despite the overlap in their responsibilities the Dardanelles Commission found that they generally worked well together.²⁹

The medical services were once again unaware of impending operations in the lead up to the August Offensive. A sudden influx of troops at Imbros on 11 July was the first clue that there may be a major campaign in the near future.³⁰ After initiating contact with Braithwaite, the Chief of the General Staff, in order to find out what medical planning was

²⁷ Lieutenant Colonel C Ryan, Evidence to DC q. 28702, TNA: CAB 19/33.

²⁸ Lieutenant Colonel C Ryan, Evidence to DC q. 28696, TNA: CAB 19/33.

²⁹ 'Final Report of the Dardanelles Commission', 1919, paragraph 168, TNA: CAB 19/33.

³⁰ Lieutenant Colonel AEC Keble, Statement to DC, TNA: CAB 19/29.

needed, Keble was told to make arrangements for a major offensive that might occur any time after 1 August.³¹ The medical services were not the only ones to have not been told of the plans. When Keble spoke to Woodward, the Deputy Adjutant-General, regarding reinforcements on 12 July, it was the first the DAG had heard of the upcoming offensive.³² Keble's plans for land and sea evacuation were then passed up the chain only to be amended and complicated by Porter, the PHTO.³³ The General Staff seemed determined to avoid direct contact with the Director of Medical Services despite the importance of the belated input from the medical services into the medical arrangements for the April Landings. In his war diary on 29 July Birrell stated:

the G[eneral] S[taff] did not confer with other staffs, so that Directors did not know what other Directors were doing and much additional work resulted. The GS did not deal direct with the DMS but through A[djutant], resulting in delay.³⁴

With only limited British medical involvement at this stage of the plans, the Australians were not yet privy to the medical arrangements for this new offensive, highlighting the way that imperial hierarchies were maintained to the detriment of military and medical concerns.

There were some lessons learnt from the April Landings that resulted in different procedures in the August Offensive. The initial casualty estimate was a more realistic 30,000 and was made by Keble, an officer of the RAMC (though the estimate was required before he was informed of the location, date, or methods to be used). Hamilton revised this number down to 20,000, which is still substantially higher than his fanciful estimate of 3,000 for the initial landings in April. With reports of the final number of casualties for August ranging from 23,000 to 30,000 Keble's estimate had the capacity to handle another military failure. The problem of not having a trained Staff Officer monitoring casualty evacuation at the corps level for ANZAC was rectified for the August Offensive, with Hamilton appointing Keble to the post. This gave a Briton responsibility for ANZAC troops rather than promoting Howse who was the logical AAMC Officer for the role.³⁵

³¹ DMS MEF, War Diary, 1 – 11 July 1915, AWM: AWM4 26/3/1.

³² DMS MEF, War Diary, 12 – 31 July 1915, AWM: AWM4 26/3/1.

³³ Lieutenant Colonel AEC Keble, Statement to DC, TNA: CAB 19/29.

³⁴ DMS MEF, War Diary, 12 – 31 July 1915, AWM: AWM4 26/3/1.

³⁵ Lieutenant Colonel AEC Keble, Statement to DC, TNA: CAB 19/29.

Despite these structural improvements in the medical arrangements for ANZAC, the lack of communication between the medical services and the General Staff continued to cause problems and the failure of the army to reach its objectives had on-going consequences for the medical services. Once Keble arrived at Anzac Cove for the August Offensive he set about ensuring that adequate arrangements were in place for the upcoming military action. He asked the Beachmaster, Lieutenant Carter of the Royal Navy, if any instructions had been forthcoming from Porter, the Principal Hospital Transport Officer. Carter advised that they had been received and went to retrieve them but he was killed before he could pass on the details of the orders to Keble. Carter's replacement, Lieutenant Drummond, could find no record of the orders in Carter's office. There was also an attack planned of which Keble was entirely unaware, and for which there were no casualty evacuation plans. He was only informed of the attack the day before it took place, leaving him with insufficient time to assemble a makeshift evacuation scheme.³⁶ The problem of the availability of personnel in August mirrored that of April with some of the medical establishment failing to arrive on the peninsula before the offensive began. However, in his statement to the Dardanelles Commission, Keble questioned the significance of this failing to the outcome of the campaign. Of the area in which the Casualty Clearing Station was intended to be pitched, he wrote that it:

was found to be absolutely untenable. Our offensive did not succeed and consequently the ground which the Casualty Clearing Station destined for No. 2 Post were to occupy was never able to be occupied; it was swept by machine gun fire, and it was certain death for anybody to go on it.³⁷

If the CCS had been established it would have been in a location that placed patients and staff in danger. This bears a remarkable similarity to the problems of the location of the 1st Australian Casualty Clearing Station during the April landings.

The lack of hospital ships created problems for the AAMC on the beach during the August operations, just as it had done during the original landings in April. During the Dardanelles Commission, Lord Nicholson asked Lieutenant Colonel John Corbin, the Medical Officer of the First Australian Casualty Clearing Station:

³⁶ Lieutenant Colonel AEC Keble, Statement to DC, TNA: CAB 19/29.

³⁷ Lieutenant Colonel AEC Keble, Statement to DC, TNA: CAB 19/29.

surely the business of improving those arrangements rested with the corps, that is to say with General Birdwood and the staff under his orders and so on, would it not?³⁸

After some clarification Corbin responded:

The chaos existed on the beach because, as I tried to make clear, there were no means of clearing the beach; that is to say there was no transport. We had limited space; we could hold in some shelter roughly 300 wounded men, that is to say they would be protected from all shrapnel fire in traverses, but after that we had to put them anywhere where they would not be protected; there was no room; and even with the 300 they were packed like herrings so that nothing could be done with them. We had our 300 on the beach, and they were still coming in, from 40 to 50 an hour and likely to be very much increased in numbers when other fighting commenced.³⁹

The similarity of this to the experience in April suggests that the MEF had failed to learn from the problems they encountered in April. In both the April and August fighting the divisions failed to reach their objectives or claim sufficient territory and, as a result, were unable to fully deploy the medical services. In both cases this meant that casualties accumulated on the beach, which needed to be cleared not only of serious cases but also those deemed to be 'less serious' or 'slight'. The problems then encountered loading casualties onto transports and from there on board ships further encumbered the ability of the medical services to provide adequate care to wounded soldiers on the beach.

After the failure of the August Offensive, the British Government decided to bring the Dardanelles Campaign to an end and made some immediate changes. The most obvious personnel changes with respect to the medical services were that Birrell and Hamilton were both relieved of their commissions. Birrell had been found wanting in the incredibly complex role he occupied and Hamilton, as the GOC MEF and the man responsible for the campaign as a whole, was roundly chastised for its failure. Within the AIF, Neville Howse was promoted to the position of Deputy Director of Medical Services for ANZAC and became responsible for the medical services at the corps level, a position he had declined at the commencement of the campaign. He declined the opportunity once

³⁸ Lieutenant Colonel J Corbin, Evidence to DC q. 28599, TNA: CAB 19/33.

³⁹ Lieutenant Colonel J Corbin, Evidence to DC q. 28600, TNA: CAB 19/33.

again but was persuaded to take on the role once Birrell and Hamilton were no longer in charge of the medical services and the MEF.

The medical services were by necessity more involved in the arrangements for the evacuation as part of the process entailed removing from Gallipoli the medical infrastructure that had been erected including Regimental Aid Posts and Casualty Clearing Stations (along with the wounded men they were treating) as well as medical stores. Had serious fighting been encountered the arrangements were to leave some medical personnel, supplies and patients behind to be collected at later date. This was planned under the assumption that the Ottoman army would continue to respect the Red Cross insignia and the Geneva Convention. The plan was, however, not enacted as there was no significant opposition from the Turks to the evacuation of the Allied troops.

Aftermath: Reorganising the Medical Services and the Dardanelles

Commission

The initial post-campaign responses to the work of the Australian Army Medical Services as part of the Mediterranean Expeditionary Force and the Force in Egypt were swift. The Director of Medical Services for the Australian Imperial Force, Surgeon General Sir William 'Mo' Williams, had been shown to be past his prime and no longer capable of performing competently in that role. He had his poorly-defined responsibilities decreased and was made Director of Medical Services for the Australian Imperial Force in the United Kingdom. Taking his place as Director of Medical Services for the Australian Imperial Force was his former Staff Officer, Neville Howse, whose promotion to Knight Commander of the Order of the Bath had been conferred as a result of his service as Medical Officer to the 1st Australian Division in the Dardanelles Campaign and his later service as Deputy Director of Medical Services (DDMS) for ANZAC. This separation of roles caused further problems, as the chain of command and the spheres of responsibility for Williams and Howse were not clear. Once Howse began to assert his authority, and Williams became aware of the constrained scope of his role, Williams returned to Australia and soon retired.

Williams had failed to impress other Australian officers despite being well-qualified and sufficiently experienced to take on the role. Major General Sir William Bridges, GOC 1st Australian Division, believed that Williams was a relic of an age gone by whose behaviour left much to be desired. Official historian Charles Bean wrote that Williams's

month on board the ship sailing from Australia was treated more like “a month at one of his clubs”.⁴⁰ There is no doubt that personality was a major factor in Williams being sidelined; however, he was also 58 years old and in poor health. The historian Michael Tyquin suggests that Williams’ heavy drinking had taken its toll and was not well-regarded by his colleagues, many of whom were teetotallers.⁴¹ The biggest factor in his professional demise was, however, not age, personality, health or relationship with his superiors, it was the fact that no one was really sure where the AAMC fit within the Australian Imperial Force, the wider British Dominion forces or the Allies more generally. Given that the Australian medical services were the particular responsibility of nobody in particular, it spelled disaster for Williams. As the man in charge he was responsible for the actions of the AAMC but had no recourse when decisions affected the ability of the AAMC to function as it had too many masters but no one in control. The AAMC variously fell under the command of Williams, Birrell and Ford (the DMS for the Force in Egypt) depending on where each unit was located, with the DMS AIF and Surgeon General in the AAMC having no authority to command AAMC units or personnel in Egypt or the MEF. This all changed after 1915 and the debacle that was the medical arrangements for the Dardanelles Campaign. Australia could no longer afford to take a passive role in medical arrangements and rely on British plans, and the man promoted to bring about this change, Neville Howse, was a strong advocate Australian medical expertise and for the importance of efficiency in wartime medical care.

The Dardanelles Commission was convened in order to investigate the failure of the campaign. It was the solution to a political problem for the British government and a number of those in positions of authority, especially Winston Churchill and Ian Hamilton, advocated for a Commission in the belief that an airing of the evidence would vindicate their actions and restore their standing in public opinion.⁴² Despite these reasons for its existence, the Dardanelles Commission’s stated purpose was:

Inquiring into the origin, inception, and conduct of operations of war in the Dardanelles and Gallipoli, including the supply of drafts, reinforcements,

⁴⁰ C. E. W. Bean, *Two Men I Knew: William Bridges and Brudenell White, Founders of the AIF* (Sydney: Angus and Robertson, 1957), 36–7.

⁴¹ Michael B. Tyquin, “Sir William ‘Mo’ Williams, KCMG, CB, KStJ, Creator of Australia’s Army Medical Services - Maligned or Misunderstood?,” *Journal of the Royal Australian Historical Society* 84, no. 1 (June 1998): 68–81.

⁴² For further information see: Trevor Wilson, *The Downfall of the Liberal Party 1914-1935* (London: Collins, 1966); Jenny Macleod, “General Sir Ian Hamilton and the Dardanelles Commission,” *War in History* 8, no. 4 (November 2001): 418–41.

ammunition and equipment to the troops and Fleet, the provision for the sick and wounded, and the responsibility of those departments of Government whose duty it has been to minister to the wants of the forces employed in that theatre of war.⁴³

It is clear from this statement of purpose that the medical services were only one part of the larger whole under review and open to criticism. The main focus of the Dardanelles Commission was not supposed to be the provision of medical care to soldiers, rather the entire Campaign was under scrutiny right from the initial ideas and planning for the war to the supply of equipment, reinforcements and care. The Commission had the full powers of a Royal Commission to compel testimony and make recommendations and it sat from August 1916 to September 1917 issuing interim reports in February and December 1917 and a final report after the end of the First World War in 1919.

Despite its stated purpose, the Dardanelles Commission became preoccupied with medical care and there were two main factors involved in why this was the case. First, by focussing on the provision of medical care and the very serious issues faced in terms of medical evacuation of wounded and sick soldiers it was possible for those who would benefit from a cursory examination of their involvement to present a compelling case where events did not run smoothly but could be shown to be outside of their own realm of control or expertise. Second, the standard of medical care provided for soldiers had become a political issue since the South African War. Mark Harrison has argued that, in Britain, governments ignored the health of the soldier at their peril – that a covenant had come to be understood as existing between the soldier and the state regarding healthcare – and the failure to provide adequate medical services to soldiers was looked upon unfavourably by the public.⁴⁴ This public concern was not new, it can be traced back to the work of Florence Nightingale in the Crimean War and the typhoid epidemics of the South African War. Fears about the transformation of public concern for the medical care of sick and wounded soldiers into political action on their behalf worried authorities and this political expediency enabled the Dardanelles Commission to emphasise the issues in the medical arrangements on par with, if not over, some of the military concerns.

⁴³ Dardanelles Commission, “First Report of the Dardanelles Commission” (London, 1918), paragraph 1, TNA: CAB 19/33.

⁴⁴ Harrison, *The Medical War*, 12.

As with all source material there are issues inherent in using the submissions, testimonies and reports that constitute the evidence given to the Dardanelles Commission to write the history of this campaign. Using the Dardanelles Commission papers to construct the history of the Dardanelles Campaign without acknowledging the context in which they were created would fail to take into account the intrinsic inconsistencies in the evidence presented to the Commission. The Commission itself was aware of these inconsistencies and made statements as to which version of events was taken as being true.⁴⁵ The level of collusion between witnesses suggests that the outcome of the Commission was susceptible to influence from those it was scrutinising. General Sir Ian Hamilton, GOC MEF, was one of the men whose actions were to come under the microscope of the Dardanelles Commission. Even a cursory reading of his personal papers demonstrates just how much he attempted to manipulate the Commission in order to have his own actions painted in a more favourable light. In her analysis of Hamilton's involvement with the Dardanelles Commission, historian Jenny Macleod stated that reading the Commission evidence in context with personal papers and military orders and reports shows that "Hamilton was not only an honourable and chivalrous soldier but also a clever and guileful political operator."⁴⁶ The problematic nature of the source material highlights the need to read the evidence of the Dardanelles Commission in conjunction with unit diaries, orders and reports from the Campaign and the personal papers of those who gave testimony.

Having ignored the members of the medical services in the planning stages of the Dardanelles Campaign, Hamilton was eager to remember them whilst giving evidence at the Dardanelles Commission and called on them to furnish him with information about medical issues.⁴⁷ Once the Commission was underway Hamilton wrote to Keogh, who had been the Director General of Army Medical Services, to request the addresses of Birrell and Keble.⁴⁸ Keogh supplied this information and then Hamilton wrote to Birrell, Keble,

⁴⁵ For example see: Dardanelles Commission, "Final Report of the Dardanelles Commission," paragraph 170, TNA: CAB 19/33.

⁴⁶ Macleod, "General Sir Ian Hamilton and the Dardanelles Commission," 420.

⁴⁷ See for example: General Sir I Hamilton to Surgeon General Sir A Keogh, 20 February, 1917, Liddell Hart Centre for Military Archives, King's College London (hereafter LHCMA): HAMILTON 8/1/37; General Sir I Hamilton to Surgeon General WG Birrell, 1 March 1917, LHCMA: HAMILTON 8/1/12; General Sir I Hamilton to Surgeon General W Babtie, 22 January 1917, LHCMA: HAMILTON 8/1/7.

⁴⁸ General Sir I Hamilton to Surgeon General Sir A Keogh, 20 February 1917, LHCMA: HAMILTON 8/1/37.

Keogh and Woodward regarding their evidence to the Dardanelles Commission.⁴⁹ Through these letters Hamilton attempted to influence the evidence presented to the Commission. Keble wrote to Hamilton: "I wrote very much on the lines you suggested, indeed I practically adopted the whole of your suggestion".⁵⁰ Woodward wrote along similar lines stating: "I have noted the four points you mention in your letter and will do all I can to produce a good case for you."⁵¹ Hamilton was not particularly discreet in attempting to influence others' testimony, writing to Birrell:

Be sure you remember to bring in (drag it in by the heels if necessary) the fact that you never heard anything about General Woodward's supposed request to Braithwaite or myself that the operations should be delayed two days. I put in myself, as you know, a very strong paragraph on this very point, but by Mears' advice I struck it out as he thought it would come so much better from you.⁵²

To do his best to ensure everyone concerned got their stories straight, Hamilton then included Braithwaite's assessment of the situation having already ascertained from him what he would write in his statement to the Commission. It is also worth noting that the Mears referred to in the excerpt above, who coached Hamilton on what to include in his evidence and what to get others to discuss for him, was Secretary to the Dardanelles Commission.

In his letters to his colleagues during the Dardanelles Commission Hamilton demonstrated how little he knew of the medical arrangements for the campaign; he was not even aware who the author of the scheme was. He wrote to Keogh:

The Dardanelles Commission (~~if it has served no other purpose~~) has at least revealed to this ex-CinC of an ill-fated enterprise the strong and weak elements in his old Staff. Only quite lately have I realised to the full (~~I always knew to some extent~~) the value of LtCol Keble to our enterprise. And now that I do realise the truth I realise also that he has been very much under rewarded. For over two years General Woodward my late DAG has claimed and thriven upon the credit due to the admirable scheme for the evacuation of the

⁴⁹ Surgeon General Sir A Keogh to General Sir I Hamilton, 21 February 1917, LHCMA: HAMILTON 8/1/37.

⁵⁰ Lieutenant Colonel AEC Keble to General Sir I Hamilton, 1 September 1917, LHCMA: HAMILTON 8/1/36.

⁵¹ Brigadier General EM Woodward to General Sir I Hamilton, 10 November 1916, LHCMA: HAMILTON 8/1/67.

⁵² General Sir I Hamilton to Surgeon General WG Birrell, 11 August 1917, LHCMA: HAMILTON 8/1/12.

wounded at the first landing. Largely on this false credit I have got him mentions, a CB, and a Major Generalship. Now it turns out that the whole of this work was Keebles' [*sic*] who has gained nothing of value through me. Well, it is never too late to put straight an injustice and I hope very much you will, at the next opportunity, remember that Keble has arrears of honours due to him.⁵³

Hamilton's lack of knowledge of the medical services' work during the Dardanelles Campaign demonstrates, if nothing more, a lack of interest in wartime medical issues. The subsequent scramble to gain an understanding of the issues suggests that Hamilton knew this was a weak point in his command of the campaign. This 'old' way of thinking about the role of medical services in war will be contrasted in the following chapters with the integration of the medical services into strategic preparations that occurred on the Western Front.

Australian Medical-Military Expertise

During the campaign Howse attracted attention because he left his transport to command the medical services and manage casualty evacuation from the beach. Howse's decision to land with his troops was considered questionable by other medical officers as it left ANZAC without an officer to direct the evacuation. As the Assistant Director of Medical Services for a division with the 1st Australian Casualty Clearing Station under his command he was supposed to be on the beach. However, there was no designated DDMS at the Corps level for ANZAC in April. Had this position existed, as it had previously in the RAMC, it should have been a trained Staff Officer whose responsibilities would have included managing the evacuation of casualties for the Corps, which included Howse's 1st Australian Division as well as the New Zealand and Australia Division. This was the role Keble was given for the August Offensive. In Howse's evidence to the Dardanelles Commission he stated that he foresaw this flaw in the medical arrangements but when he questioned the arrangements prior to the landings he was told "a corps was not entitled to any senior officer under the Establishment then existing, and it had been refused".⁵⁴ Therefore, the lack of a medical officer at Corps level was a structural problem within the AIF. Howse perceived the deficiencies in the medical arrangements and was prevented

⁵³ General Sir I Hamilton to Surgeon General Sir A Keogh, 31 August 1917, LHCMA: HAMILTON 8/1/37; Hamilton's emphasis and crossing out.

⁵⁴ Surgeon General Sir NR Howse, Evidence to DC q. 27663-4, TNA: CAB 19/33.

from altering the structure of the medical corps in order to rectify the problems, but was then subject to unfair criticism for his decision to obey orders and remain with his Division and Casualty Clearing Station for the landings. Colonel Keble, the Staff Officer to the Director of Medical Services for the Mediterranean Expeditionary Force, suggested in a statement for the Dardanelles Commission that, despite being ordered not to, Howse missed a chance to step up and fill the role of DDMS for ANZAC. He said of Howse:

In my opinion Colonel House [*sic*] lost an opportunity which comes very seldom to anybody, but I do not blame him because he was not a soldier nor was he a trained Staff Officer. Had he been a trained Staff Officer he would not have left his ship. Previous to the war he was a surgeon in a small country town in Australia, and his only military experience as far as I knew was as medical officer to an Australian unit during the South African War.⁵⁵

This statement represents a three-pronged critique of Howse. He was a civilian, from the country and, finally, a colonial. To Keble, military training and expertise were more important than medical expertise or experience as a medical officer in a previous war. Whilst rural living had been equated with a rugged masculinity, the rural doctor was seen as more closely resembling his city counterparts than his local patients, but without the diversity of cases and experience available to those practising in large cities. At the time of the campaign Howse was not an inexperienced provincial GP, as was sometimes claimed. Howse had served in the South African War in the medical corps and had been awarded a Victoria Cross for gallantry. He had also led the medical contingent in the Australian Naval and Military Expeditionary Force that captured German New Guinea in the first months of the First World War. He was not a regular member of the Australian Army Medical Corps – the peacetime establishment for the Corps before the war was four men – but he was not unaccustomed to, or unaware of, the workings of a medical Corps in wartime.

Hamilton did not think that Australia had any men suitable for positions as commanding officers of medical or combat units. When questioned by the Australian Governor-General about the promotion of Australian officers, Hamilton responded:

The fact is, it takes a long time to manufacture a true military character and frame of mind, although all the actual work he has to do, and decisions he has to take, may appear on paper so simple and so easy ... So far I am at present

⁵⁵ Lieutenant Colonel AEC Keble, Statement to DC, TNA: CAB 19/29.

aware the Australians, magnificently as their fighting men have done, have not yet produced many of that peculiar calibre.⁵⁶

The criticism of Howse already mentioned, that he left his ship and was too eager to manage events from the beach, is harsh. Howse had limited options available to him when Hamilton had refused to grant him the authority and resources to effectively act as the senior medical officer of the corps.

In response to the disregard shown by members of the British army for Australian medical-military expertise a number of Australians attempted to assert that expertise and demonstrate it to the British authorities. One example of this is the interaction of Neville Howse and Andrew Fisher at the Dardanelles Commission. Fisher was the Australian member of the Dardanelles Commission, a former Prime Minister of Australia, and the Australian High Commissioner to the UK at the time. Fisher sat on the Commission with the permission of the Australian government but as the Australian government was not consulted in the drawing up of the terms of reference for the Commission he was not to be considered to be formally representing or speaking for Australia. His framing of questions to Neville Howse emphasised Howse's experience and knowledge. In order to establish Howse's military credentials Fisher asked: "And you fought in Africa, did you not, and won the highest honour a man can win?"⁵⁷ Regarding the medical arrangements for the landings and whether or not a conference of medical officers had taken place, Fisher asked Howse: "You were not consulted in any way, notwithstanding your knowledge of war work as a medical officer?" Howse responded: "No, there was no conference and no consultation of medical officers, with the exception of that time when I had a discussion with Colonel Kebbell [*sic*]."⁵⁸ Fisher then established that it was Howse who had initiated that conference before continuing the examination in a way that allowed Howse to demonstrate his competence.⁵⁹ Fisher said: "You foresaw the danger and you pointed it out to the officers you had access to in language that could not be misunderstood".⁶⁰ This was followed by: "You did everything a man could do with safety to see that better arrangements were made".⁶¹ And finally: "I, as a layman, think it would be the duty, whatever ability the

⁵⁶ Hamilton to Munro-Ferguson, 6 October 1915, LHCMA: HAMILTON 7/1/42.

⁵⁷ Surgeon General Sir NR Howse, Evidence to DC q. 27677, TNA: CAB 19/33.

⁵⁸ Surgeon General Sir NR Howse, Evidence to DC q. 27869, TNA: CAB 19/33.

⁵⁹ Sir A Fisher to Surgeon General Sir NR Howse, Evidence to DC q. 27870, TNA: CAB 19/33.

⁶⁰ Sir A Fisher to Surgeon General Sir NR Howse, Evidence to DC q. 27871, TNA: CAB 19/33.

⁶¹ Sir A Fisher to Surgeon General Sir NR Howse, Evidence to DC q. 27872, TNA: CAB 19/33.

command had, to have had a free consultation on the matters”.⁶² This succession of questions and statements established Howse’s credentials and portrayed him as a man of foresight. The questions enabled Howse, in his answers, to demonstrate that he had done what he could to improve the medical arrangements before the landings on the Gallipoli Peninsula. The last of the three statements just mentioned presents Howse as a man of sense. By describing himself as a ‘layman’ who finds it obvious that a consultation on medical issues should take place, Fisher positions the General Staff as lacking in even the most basic common sense possessed by a civilian colonial politician. Having demonstrated that Howse had the appropriate experience and expertise to critique the medical arrangements Fisher asked Howse the final question in his evidence: “Was it rather the system do you think or the man which caused the trouble - was it a case of do as you are told?” This then enabled Howse to make his assessment of the situation, which he did in a way that once again demonstrated that he was excluded from the planning stages. He stated: “That is assuming there was no consultation; but I do not know. There may have been perfect coordination between the Navy and the Army people of which I have no knowledge; but I do not believe it existed or there could not have been the breakdown which took place.”⁶³

It is significant that it was necessary to use the forum of the Dardanelles Commission to assert Australian medical-military expertise. Australian medical officers had their authority undermined and their expertise de-valued during the campaign and the Dardanelles Commission provided an opportunity to air those grievances. This critique was partly based on the perception of their skills as doctors, though their readiness to assume roles as Officers in a wartime army was as important. Given the nature of their medical education, this critique may have surprised many of the Australian doctors in the AAMC. In his PhD thesis, Bryan Egan found that the Australian doctors who served in the AAMC were either educated in Britain or, if they were educated in Australia, were educated in a system which was based on that found in Britain. He particularly noted the influence of the Edinburgh style of medical training and its emphasis on anatomy. These doctors had been the recipients of a “British education in Australia”.⁶⁴ Australia’s medical services had a pre-

⁶² Sir A Fisher to Surgeon General Sir NR Howse, Evidence to DC q. 27873, TNA: CAB 19/33.

⁶³ Sir A Fisher to Surgeon General Sir NR Howse (and response), Evidence to DC q. 27874, TNA: CAB 19/33.

⁶⁴ Bryan Egan, “Nobler Than Missionaries?: Australian Medical Culture 1880 - 1930” (PhD Thesis, Monash University, 1988).

war, full-time staff of four officers, yet many Australian doctors still had some military experience. Michael Tyquin found that, in 1910, there were 700 militia doctors attached to the AAMC.⁶⁵ Based on this number, together with statistics from the Commonwealth statistician, Kate Blackmore has suggested 25 per cent of doctors who practiced medicine in Australia were involved in military activities in 1910, when there was no conflict on the horizon.⁶⁶ Tyquin also suggested that as of September 1914 all but eight members of the AAMC had some level of military experience.⁶⁷

Instead of viewing the similarities between Australians and British people as evidence for the competence and capability of Australians, this idea of Britons in Australia is one of the reasons given for the exclusion of Australians from the planning of medical arrangements. By the time of the Dardanelles Commission Keble had become aware of the problems caused by the view that Australians were Englishmen living in the antipodes. He wrote to the Dardanelles Commission:

My opinion...is that the Australians felt themselves left out from the higher command. I, together with the whole of the General Headquarters Staff, and I expect a greater part of England, had an idea that Australians were Englishmen living in Australia; whereas as a matter of fact I have since – and so have others – found that an Australian is not an Englishman but is an Australian, a member of a new Nation secondarily a member of the British Empire. Had General Headquarters recognised this fact, an Australian officer would have been attached to every branch as liaison officer, and the Australians would have felt that they were taking part in the higher command of the expedition and very few of the complaints which did arise would then have arisen.⁶⁸

It is worth noting that Keble is suggesting that the Australians would have *felt* like they were taking part in the decision-making processes, not that their views would actually be listened to or taken into account.

The Australian forces and the AAMC were subordinate to the British army. However, Howse, Bridges, and Birdwood all thought that they had a responsibility not just

⁶⁵ Michael B. Tyquin, *Little by Little: A Centenary History of the Royal Australian Army Medical Corps* (Sydney: Australian Military History Publications, 2003), 100.

⁶⁶ Kate Blackmore, *The Dark Pocket of Time: War, Medicine and the Australian State, 1914-1935* (Adelaide: Lythrum Press, 2008), 87.

⁶⁷ Tyquin, *Little by Little*, 100.

⁶⁸ Lieutenant Colonel AEC Keble, Statement to DC, TNA: CAB 19/29.

based on their rank and position, but on their roles as commanders of Australian men (this despite none of them spending any of their childhood in Australia, nor identifying as 'Australian'). The rigidity of the command structure of the British army was such that there was no regard for the countries that made up a Corps. Information was disseminated according to rank and not national affiliation. After he stated that he would recommend to the Australian government that they never again trust the Imperial authorities with medical arrangements for Australian troops, Howse suggested that it would be a difficult thing for him to do. He said: "it is an opinion, unfortunately, which I have had to form because I am an Englishman myself; I am merely an adopted Australian."⁶⁹

As a result of the Dardanelles Campaign the Australian Army Medical Corps sought greater autonomy. After many communications between the Australian Defence Department, the War Office and various members of the AAMC and AIF, Neville Howse was promoted to Surgeon General and made the Director of Medical Services for the AIF. Every AIF medical unit serving outside of Australia came under his command and he became the medical adviser to the Australian Government. Howse's own views were instrumental in achieving this and he agitated for an independent AAMC despite significant opposition from the War Office, Defence Department and some members of the AAMC.⁷⁰ To the Dardanelles Commission he said: "if I had an opportunity today of advising my Government, I would say we are entitled to some control over the arrangements that are made for our sick and wounded".⁷¹ The internal structure of the AAMC was altered and those positions that had been lacking at Gallipoli were incorporated into the new structure. Australian base and line-of-communication units were created, a system of evacuation of Australian soldiers was developed, and Howse established a working relationship with Sir Alfred Keogh who continued as the British Director General of Army Medical Services at the War Office. Under Howse's leadership, the First World War saw increasing Australian responsibility for Australian casualties.

The Medicalisation of the Military

The deliberate exclusion of the medical services from the strategic planning for the Dardanelles Campaign demonstrated an old way of thinking about the role of the medical

⁶⁹ Surgeon General Sir NR Howse, Evidence to DC q. 27676, TNA: CAB 19/33.

⁷⁰ Butler, *The AAMS in the War of 1914-1918*, 1938, 1:429-35.

⁷¹ Surgeon General Sir NR Howse, Evidence to DC q. 27757, TNA: CAB 19/33.

services in the armed forces. Harrison suggests that this would not have happened on the Western Front “where medical considerations were central to the planning and conduct of operations.”⁷² The cultures differed between the two theatres of war due, in large part, to the people who conducted the campaigns. The staff at GHQ MEF were not the best the British army had to offer – those soldiers were already occupied on the Western Front. The members of the MEF staff were relics of a bygone era and some, such as Birrell, were in fact brought out of retirement in order to serve. Commander in Chief of the Mediterranean Expeditionary Force, Sir Ian Hamilton, had been the Chief of Staff to Kitchener in the South African War and was, according to Robin Prior, “a man who it can reliably be said knew little of the Dardanelles, the Turkish army or of modern war”.⁷³ Prior notes that Hamilton “was 61 and had been plucked from Central Command in England, hardly the most prestigious of posts”, and suggests Hamilton went ahead with the campaign despite its change from a naval offensive with backup ground troops to a full-scale amphibious landing because it “was clearly his last chance to command troops in the field”.⁷⁴ His method of command was to exclude the auxiliary services from strategic planning and have the General Staff control medical planning.

Over the course of the campaign Medical Officers from both Britain and Australia sought greater authority over medical issues. This included the logistical arrangements for casualty evacuation. Birrell, Keble and Howse were all increasingly vocal in their advocacy of medical control of medical issues. This process has been described by Mark Harrison as the ‘medicalisation of the military’. He argues that the incorporation of the medical services into strategic planning was not “a function of scientific and technological advances (of the emergence of bacteriology, antiseptic surgery and so forth)”.⁷⁵ Rather, this phenomenon was an expression of Max Weber’s theory of rationalisation that promoted the quest for efficiency and the maximisation of resources, including manpower through the prevention of sickness and the efficient return to service of wounded men. Harrison also questioned the morality of this process and acknowledged that Weber “was uneasy about the subjugation of human beings to what he termed a ‘means-ends’ rationality ... which objectified and depersonalised the individual”.⁷⁶ Harrison posits the idea that this process

⁷² Harrison, *The Medical War*, 203.

⁷³ Robin Prior, *Gallipoli: The End of the Myth* (Sydney: UNSW Press, 2009), 67.

⁷⁴ Prior, *Gallipoli*, 82.

⁷⁵ Harrison, “Medicine and the Management of Modern Warfare: An Introduction,” 2.

⁷⁶ Harrison, “Medicine and the Management of Modern Warfare: An Introduction,” 2.

resulted in the increasing medicalisation of the military and, conversely, the militarisation of medicine, themes he has also discussed elsewhere.⁷⁷

The medicalisation of the military was evident in the increasing participation of the medical services in the action of the army and Harrison's definition of medicalisation provides a solid foundation for this analysis. He stated:

By medicalization, we mean the gradual extension of medical authority into new areas such as discipline and administration, together with the growing authority of medical men in the planning and conduct of military campaigns. While recognising that the process of medicalization was partial and often highly contested, the term nevertheless encompasses a complex of interconnected changes that occurred in the armed forces of most industrialised nations from the middle of the nineteenth century.⁷⁸

Despite, and partially as a result of, its exclusion from the planning at Gallipoli, over the course of the First World War, the AAMC would exert influence over a wide range of areas in the military. The medical services were involved in the recruitment of soldiers. They undertook physical checks of soldiers' bodies at the point of enlistment and they provided expert advice on the appropriate diet for soldiers. The medical services became more involved in the planning of military campaigns and were incorporated into the process for making decisions regarding casualty clearance, location of aid posts and the medical duties of regimental medical officers. The medical services also came to be involved in all aspects of the health of the soldier and were the primary vehicle through which the state attempted to control the body of the soldier. They were responsible for sanitation and for educating soldiers in the appropriate methods of waste disposal. The development and implementation of new vaccines were also undertaken by the medical services. They were responsible for campaigns based on health and moral issues including those regarding venereal disease. All of this medical decision making took place in addition to the treatment and rehabilitation of sick and wounded soldiers and demonstrates that the medical services in the First World War developed into a very different force to the providers of care and comfort that they were seen as in earlier conflicts.

⁷⁷ Mark Harrison, "The Medicalization of War—The Militarization of Medicine," *Social History of Medicine* 9, no. 2 (1996): 267–76.

⁷⁸ Harrison, "Medicine and the Management of Modern Warfare: An Introduction," 4.

The increasing militarisation of medicine is a less easily defined phenomenon, but, Harrison, along with Steve Sturdy and Roger Cooter, have argued for its existence.⁷⁹ Harrison suggests that Britain was a far less militarised state than Germany, for example, which is routinely held up as the example of a militaristic society in the late nineteenth and early twentieth centuries. Whilst he argues that British militarism was less overt and more like a form of 'liberal militarism', Harrison states: "it was militarism nonetheless".⁸⁰ Citing examples such as the quasi-military style of organisations such as the scouts and the increasing popularity of 'muscular Christianity', Harrison argues that British society was more militaristic than has been previously considered and he suggests that the process of militarisation of medicine is demonstrated in nursing. The use of military style uniforms and the introduction of hierarchies reminiscent of military ranks can be considered examples of this phenomenon. Harrison also makes clear that the discourse of disease has become militarised as well. Doctors fight disease, those who harbour disease are the enemy, and titles of the literature published in this period reflect this.⁸¹ This changing discourse, which portrayed medicine as sublimation of war, can be read as an attempt by the medical services to legitimise their place in the increasingly rationalised military.

Whilst there was a discernable medicalisation of the military evident in the British army, the AAMC was not satisfied with its level of control over medical issues. This dissatisfaction was complicated by the desire not just for medical control of medical issues but Australian medical control of Australian medical issues. As a result, the medical services lobbied both the AIF and also the Australian government for greater Australian responsibility for sick and injured Australian soldiers. Given the ill-fated expedition in the Mediterranean it was not difficult for them to make the case that Australian soldiers were disadvantaged by Australia's position subservient to Britain. As a consequence, and as will be seen in subsequent chapters, the AAMC was granted greater autonomy and responsibility for Australian casualties once the AIF shifted its focus to the Western Front. The Dardanelles Campaign made evident the dire consequences of failing to integrate the medical services into strategic planning in modern warfare. The Dardanelles Commission enabled Medical Officers to articulate their foresight and expertise. As a result, the medical

⁷⁹ Harrison, "Medicine and the Management of Modern Warfare: An Introduction," 4–5.

⁸⁰ Harrison, "Medicine and the Management of Modern Warfare: An Introduction," 5.

⁸¹ Harrison, "Medicine and the Management of Modern Warfare: An Introduction," 4–6.

services established themselves as competent custodians of medical issues and were then able to assert greater influence over medical issues on the Western Front.

Much has been written about the significance of the Dardanelles Campaign to Australian nationhood. Whilst I reject the idea that the Australian nation was created at Gallipoli, this aspect of Australian's participation in the Dardanelles Campaign did result in a British-Australian divergence. The medical services are an example of a small, tangible, practical way in which, as a result of action on the beaches of Gallipoli, Australia stepped away from its colonial past. Additionally, it was not inevitable that Australia's first major battle would result in this divergence. As will be seen in subsequent chapters, there is sufficient evidence to suggest that had Australia's first engagement occurred in different circumstances, such as the more consultative command structure that Mark Harrison has argued already existed on the Western Front, then the drive toward military independence may not have been so strong. The move towards self-sufficiency for the Australian Army Medical Corps was a reaction to the inadequacy of the medical arrangements, the lack of Australian control of Australian casualties and the lack of recognition for Australian medical-military expertise. The Dardanelles Campaign, and its aftermath, fundamentally changed the way the AAMC provided medical care during the First World War.

Chapter Two

Medicine in the Lines: Stationary Warfare on the Western Front, 1916-1917

In his analysis of the Australian Army Medical Services (AAMS) in the First World War, Colonel Arthur Graham Butler, the official historian, evaluated the medical arrangements for Australians in the June 1917 Battle of Messines. He wrote:

In the very elaborate medical arrangements for “Messines” every possible factor in the problem of collecting, clearing, treating and evacuating casualties, was foreseen and exactly provided for. As it turned out, “events” were in so close accord with “arrangements” that, as an exposition of military medical technique, an account of the medical features of the battle may be based on either.¹

This description of the medical provisions at Messines stands in stark contrast to the medical care provided to wounded and sick soldiers at Gallipoli. In roughly 18 months, from the conclusion of the Gallipoli campaign to the Battle of Messines, the Australian Army Medical Corps (AAMC) underwent a series of beneficial changes to both its internal structure and to the way it worked with external organisations, especially the Royal Army Medical Corps (RAMC). These changes enabled the AAMC to take increasing responsibility for planning the evacuation and treatment of Australian casualties. As a result, the medical arrangements for Australian soldiers at the Battle of Messines were entrusted to Australian medical men.

The AAMC was relocated to the Western Front along with the majority of the AIF in early 1916, after the conclusion of the Gallipoli campaign. Once in France the Australian forces remained a small part of the British forces attempting to wage a cohesive war along a protracted front. By examining the work of the AAMC on the Western Front in 1916 and 1917, this chapter traces the development of casualty clearance and evacuation during this period. In doing so it considers the relatively short battles of Fromelles, Pozières and Mouquet Farm (all battles within the broader Battle of the Somme) in 1916 and Messines in 1917 before analysing the extended four-month Battle of Passchendaele, also known as the Third Battle of Ypres.

¹ Arthur G. Butler, *The Australian Army Medical Services in the War of 1914-1918: The Western Front*, vol. 2 (Canberra: Australian War Memorial, 1940), 160.

As discussed in the previous chapter, Mark Harrison, examining the British context, compared the lack of integration of various branches of the military during the Dardanelles Campaign to the command on the Western Front.² He suggested that a more consultative and inclusive approach to planning existed in the European theatre. He argued that the most important factors in the successful development of the medical services on the Western Front over the course of 1916 to the armistice in November 1918 were “coordination between different branches of the Army and flexibility, which in turn depended on good staff work and excellent communications”.³ He also argued that the work of senior commanders facilitated the success of the medical services: “Above all, perhaps, there was a high degree of trust and mutual respect between different branches of the Army; something which was actively encouraged by senior commanders.”⁴ A military hierarchy that actively supported interaction, trust, and mutual respect between branches of the Army was the antithesis of medical care in the Dardanelles Campaign. Harrison also found that “the development of the medical services was a vital element of the reforms which transformed the BEF into a war-winning force”.⁵ This chapter asks if these findings can be extended and applied to the Australian context and questions whether the inclusion, consultation, and trust, of which Harrison writes, were also extended to the Australian forces. I argue that the decisions made regarding the structure of the medical evacuation were increasingly made by medical men for medical rather than military reasons. I also argue that these decisions, made by doctors, were frequently made collaboratively, with AAMC officers discussing changes to arrangements before seeking approval from their superiors, thereby subverting traditional military hierarchies.

The Somme: Australians on the Battlefield in 1916.

The original Australian and New Zealand Army Corps (ANZAC), which was, in part, made up of the 1st Australian Division and the New Zealand and Australian Division, was restructured in Egypt in February 1916 as part of the response to the failure at Gallipoli and the impending move to the Western Front. Two corps were created with both the 1st and 2nd Australian Divisions and the New Zealand Division forming I ANZAC and the

² Mark Harrison, *The Medical War: British Military Medicine in the First World War* (Oxford: Oxford University Press, 2010), 203.

³ Harrison, *The Medical War*, 120.

⁴ Harrison, *The Medical War*, 120.

⁵ Harrison, *The Medical War*, 65.

new 4th and 5th Australian Divisions and the British 25th Division coming together to form II ANZAC. In March 1916 I ANZAC was shipped to France under the command of General William Birdwood, who had commanded ANZAC at Gallipoli and was made the commander of the AIF in 1915, and the corps was attached to the British Second Army under General Sir Hubert Plumer. In July 1916 I ANZAC was transferred to General Sir Hubert Gough's Fifth Army and took its place in the force to attack Pozières. At this time further changes were made to the organisation of the two ANZAC Corps as General Alexander Godley, commander of the New Zealand Expeditionary Force (NZEf), was appointed commander of II ANZAC and, in order to consolidate commands, the New Zealand Division from I ANZAC and the 4th Australian Division from II ANZAC traded places. As a result of this change Godley was responsible for New Zealand's troops as both the commander of the NZEF and the corps containing the New Zealand Division. The Battle of the Somme did not involve II ANZAC Corps in a significant way; however, the 5th Australian Division was attached to the British XI Corps for the Battle of Fromelles.

The Battle of the Somme (1 July – 18 November 1916) was the Australian Imperial Force's (AIF) first engagement on the Western Front in the First World War. Four of the five Australian divisions were involved in the fighting (the 3rd Australian Division did not arrive in France until November 1916). From within the Battle of the Somme, this chapter focuses on the three main battles in which the Australian divisions fought, the Battles of Fromelles, a subsidiary attack to the Battle of the Somme, as well as Pozières, and Mouquet Farm (it does not attempt to examine the smaller scale shellings or trench raids that took place along the line during 1916). The medical services and their plans for casualty evacuation and treatment were placed under the most stress during these periods of intense fighting so this chapter examines the work of the medical services whilst under peak pressure.

The Battle of Fromelles

The Battle of Fromelles was not an integral part of the main Battle of the Somme. Rather, it was an attempt by the British forces to draw German troops and firepower away from the main battlefield and secure an advantageous position around the village of Fromelles in Northern France. The 5th Australian Division was attached to the British XI Corps, First Army, for the battle which commenced in the evening of 19 July 1916 and ended the following morning with the 5th Australian Division having incurred 5533 casualties, a

number which still places it as the worst twenty-four hours in Australian military history.⁶ Fromelles was in the so-called 'nursery sector', used to train up inexperienced troops prior to their move to the main part of the line. The 5th Australian Division was there as it had never before been involved in combat and was in the line at Fromelles in order to acclimatise to trench conditions and participate in small-scale trench raids of the German lines.

Colonel Charles Henry William Hardy, the Assistant Director of Medical Services (ADMS) for the 5th Australian Division, was responsible for the evacuation of casualties at divisional level. It is unclear from his war diary when exactly he was first made aware of the intention to use his division in the attack on Fromelles but it appears to be soon after planning commenced. On 8 July 1916 Lieutenant-General Sir Richard Haking, commander of the British XI Corps, was ordered by General Sir Charles Monro, First Army commander, to prepare plans for an attack against the German line at the boundary between the First and Second Armies.⁷ On 9 July 1916 the 4th Australian Division was moved to Pozières and the 5th moved in to take over the various posts. There was some confusion over which posts the Division was to occupy as orders, from the Deputy Director of Medical Services (DDMS) at corps level, not to take over particular posts were immediately countermanded by the Director of Medical Services (DMS).⁸ In the week following the orders Hardy spent considerable time ensuring that the 5th Australian Division was ready for battle. He inspected, and intervened to fix when necessary, the sanitation and hygiene provisions at divisional medical posts, and sought an adequate supply of stretchers, dressings, and motor ambulances.⁹ On 15 July 1916 Hardy wrote in his war diary: 'Under instructions from DDMS 2nd ANZAC attended DMS 2nd Army after am reported on steps I had taken with reference to operation orders.'¹⁰ This suggests that at some point between 8 and 15 July Hardy had been ordered to prepare for battle. The specific orders for the Battle of Fromelles were issued to the First Army on 15 July 1916

⁶ Major General JW McCay to Headquarters XI Corps, 25 July 1916, War Diary Appendix E, Formation Headquarters, 5th Aust. Div. – July 1916, Australian War Memorial (hereafter AWM): AWM4 1/50/5 Part 3.

⁷ C. E. W. Bean, *The Australian Imperial Force in France, 1916*, 12th ed., vol. 3, The Official History of Australia in the War of 1914-1918 (Sydney: Angus and Robertson, 1941), 331.

⁸ Colonel CHW Hardy, War Diary 9-10 July 1916, ADMS 5th Aust. Div. – July 1916, AWM: AWM4 26/22/6 Part 1.

⁹ Colonel CHW Hardy, War Diary 10-14 July 1916, ADMS 5th Aust. Div. – July 1916, AWM: AWM4 26/22/6 Part 1.

¹⁰ Colonel CHW Hardy, War Diary 15 July 1916, ADMS 5th Aust. Div. – July 1916, AWM: AWM4 26/22/6 Part 1.

and it was on this date that Hardy received orders to plan for the evacuation of casualties from the impending attack on what was known as the sugarloaf salient.¹¹ This is a significant improvement from the treatment of the medical services at Gallipoli. Hardy had been given sufficient warning of an attack to improve sanitation and hygiene, settle into new positions and ensure adequate provisions of medical stores. The same day that specific orders were given regarding the assault, the medical units were informed of the details and Hardy was commanded to make casualty evacuation plans. Whether this was an example of Gary Sheffield's 'learning process' or Mark Harrison's explanation that a more consultative approach existed on the Western Front, or some combination of the two, the medical services were included in the process much earlier in the planning stages for Fromelles than they were for Gallipoli.¹²

The early involvement of the medical services did not necessarily ensure smooth process as the command structure was still muddled. Hardy recorded:

Reported to G[eneral] O[fficer] C[ommanding] 5th Aust. Division that DMS 2nd Army had instructed me to draft a plan of operations to evacuate to Estaires. This he disagreed with and ordered me to prepare a plan to evacuate to Bailleul.¹³

On 15 July, after a conference of officers, Hardy prepared a plan to evacuate casualties to Bailleul, taking into account the General Officer Commanding's (GOC) intention to close the routes through Le Nouveau Monde and Sailly. This plan required him to establish another Main Dressing Station and the only suitable place was a 'manufactory' that was already partly occupied by the artillery. Hardy wrote that he "took up the large vacant machinery rooms & Colonel Kershaw OC Artillery & Captain Carter RMO kindly gave up portions of the building and shared the Dressing Station."¹⁴ The following day, 16 July 1916, Hardy issued '5th Australian Divisional Medical Order No. 1', which stated that "Arrangements are being made for an attack on the enemy's front line system" and then detailed the location and staffing arrangements for the divisional and Field Ambulance

¹¹ Bean, *The AIF in France, 1916*, 3:334; Colonel CHW Hardy, War Diary 15 July 1916, ADMS 5th Aust. Div. – July 1916, AWM: AWM4 26/22/6 Part 1.

¹² Gary Sheffield, *The Chief: Douglas Haig and the British Army* (London: Aurum, 2011); Harrison, *The Medical War*.

¹³ Colonel CHW Hardy, War Diary 15 July 1916, ADMS 5th Aust. Div. – July 1916, AWM: AWM4 26/22/6 Part 1.

¹⁴ Colonel CHW Hardy, War Diary 15 July 1916, ADMS 5th Aust. Div. – July 1916, AWM: AWM4 26/22/6 Part 1.

units.¹⁵ Ominously, Hardy indicated to his medical officers that “preparations are to be made for heavy casualties”.¹⁶ The statement regarding the levels of cooperation between the artillery and battalion and brigade level medical services supports Mark Harrison’s findings of a more integrated force on the Western Front when compared to the command of the Gallipoli Campaign.

The three Australian Field Ambulance (AFA) units of the 5th Australian Division, the 8th, 14th and 15th (8AFA, 14AFA, 15AFA) were prepared and ready to start receiving casualties before the battle commenced. On 18 July 1916 the Commanding Officer (CO) of the 8th Australian Field Ambulance, Colonel Shepherd, issued orders to the AAMC members under his command and wrote to Colonel Hardy “All other arrangements mentioned in Operation Order No. 1 have been completed.”¹⁷ The COs of the 14th and 15th AFAs also recorded in their war diaries that they were in position and prepared to receive casualties the day before the attack commenced.¹⁸ The Commanding Officer of 15AFA reported that Colonel Hardy had inspected all medical posts and on his recommendation a few minor alterations were made to the deployment of medical personnel. The length of the evacuation route appears to have caused some consternation as Bullen recorded in his War Diary: “A much shorter motor route was arranged with the additional advantage of passing along unfrequented roads – this greatly facilitated the subsequent work of collecting.”¹⁹ This change would have helped to avoid congestion on the roads; when they had to be used for both re-supplying combat units and for the evacuation of casualties one had to be prioritised and it was almost always the re-supply of combat units that took precedence. These three field ambulance units and the divisional medical units provided medical care to 3277 soldiers between noon on 19 July and 8pm on 21 July 1916. If the total casualty number of 5533 is correct, 2256 officers and men of the

¹⁵ Colonel CHW Hardy, ‘5th Australian Divisional Medical Order No. 1’, 16 July 1916, War Diary Appendix, ADMS 5th Aust. Div. – July 1916, AWM: AWM4 26/22/6 Part 1.

¹⁶ Colonel CHW Hardy ‘5th Australian Divisional Medical Order No. 1’, 16 July 1916, War Diary Appendix, ADMS 5th Aust. Div. – July 1916, AWM: AWM4 26/22/6 Part 1.

¹⁷ CO 8th Aust Field Ambulance AIF to ADMS 5th Division, 18 July 1916, War Diary Appendix 6, 8th Australian Field Ambulance – July 1916, AWM: AWM4 26/51/6.

¹⁸ Lieutenant-Colonel AH Tebbutt, War Diary 18 July 1916, 14th Australian Field Ambulance – July 1916, AWM: AWM4 26/57/6; Captain N Bullen, War Diary 18 July 1916, 15th Australian Field Ambulance – July 1916, AWM: AWM4 26/58/3.

¹⁹ Captain N Bullen, ‘Report on Work Done by Ambulance During Action of 19th, 20th, 21st July’, War Diary Appendix 22, 15th Australian Field Ambulance – July 1916, AWM: AWM4 26/58/3.

5th Australian Division died or went missing before they reached a field ambulance unit. The cases treated by the 8th, 14th and 15th AFAs are shown in Figure 2.1 and Figure 2.2.

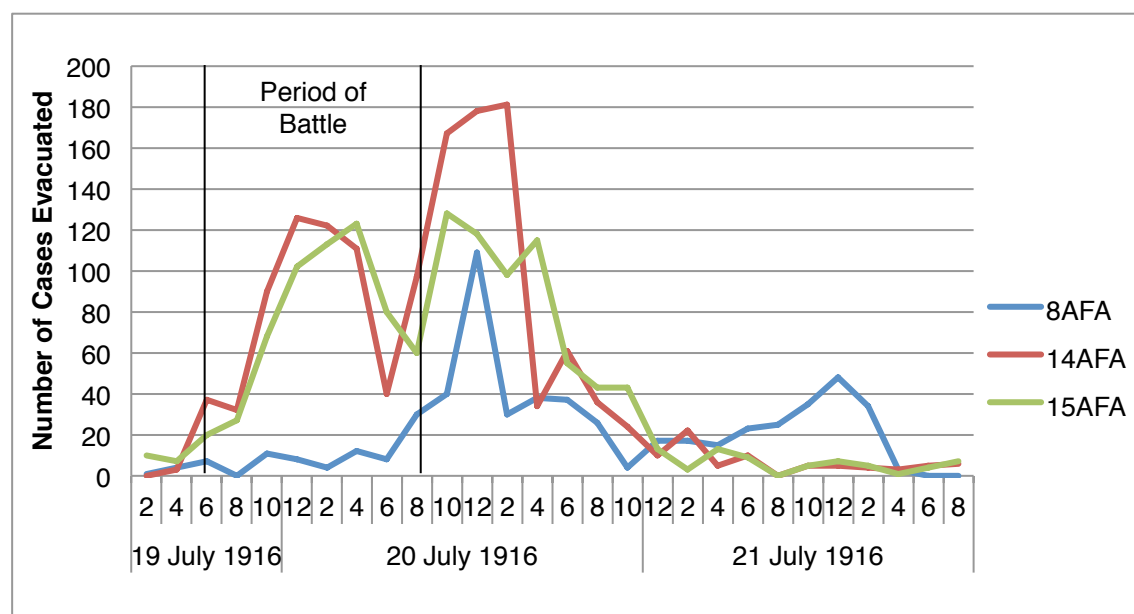


Figure 2.1: Cases through AFAs from 12 noon, 19 July to 8pm, 21 July 1916 by AFA²⁰

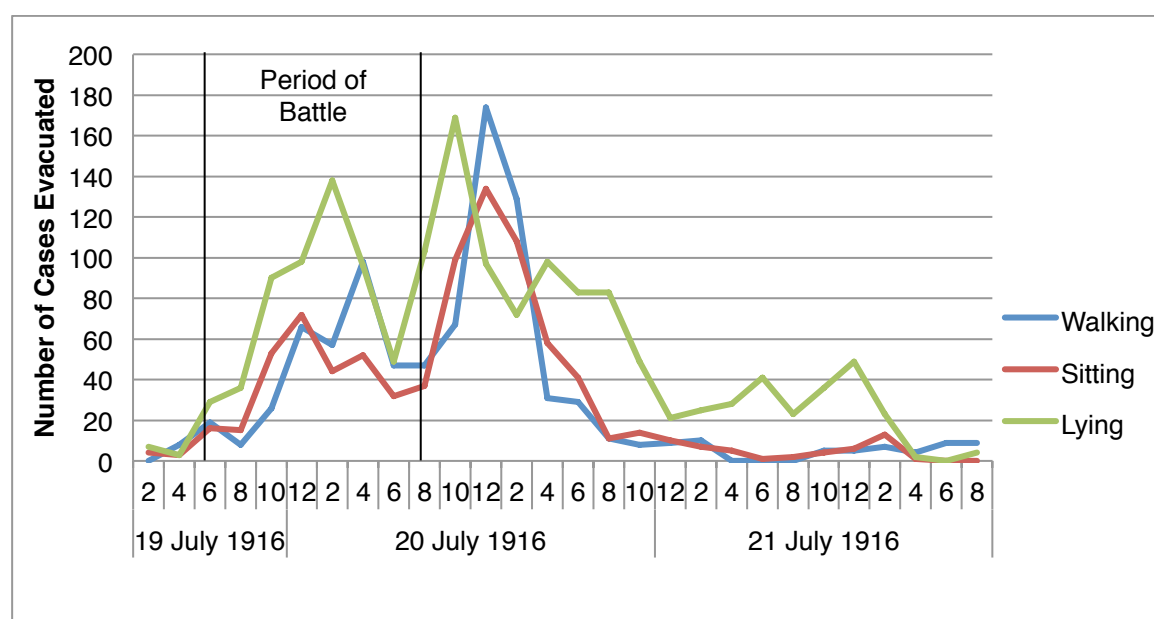


Figure 2.2: Method of carry through AFAs from 12 noon, 19 July to 8pm, 21 July 1916²¹

The evacuation statistics for the 5th Australian Division show that the majority of casualties were evacuated from the centre and right parts of the line where the 14th (43 per

²⁰ Compiled from 'Number of Cases Passed through Field Ambulances', War Diary Appendix 34, ADMS 5th Aust. Div. July 1916, AWM: AWM4 26/22/6 Part 1.

²¹ Compiled from 'Number of Cases Passed through Field Ambulances', War Diary Appendix 34, ADMS 5th Aust. Div. July 1916, AWM: AWM4 26/22/6 Part 1.

cent) and 15th (39 per cent) AFAs were positioned, whereas 8AFA on the left of the line evacuated 18 per cent of the casualties. Colonel Shepherd, Officer Commanding 8AFA, was keen to highlight that, despite the comparatively low number of casualties evacuated through the Field Ambulance, it was still under strain. He wrote:

Although the portion of the line (left) served by 8th Field Ambulance did not evacuate many casualties yet as the action progressed the Ambulance furnished assistance to all portions of the line even the extreme right from where most of the casualties admitted arrived. Although the casualties admitted do not appear large it must be borne in mind that every officer & man were distributed in every ADS and RAP over the whole front and thus the work done was much greater than appears from the records. Officers & men of the Unit in my opinion carried out their duties magnificently. Nothing was to [*sic*] big for them to tackle & every available man including transport detail, batmen, dental detail & office staff were in the field and struggled on although completely exhausted, till the area was clear of wounded.²²

Hostilities commenced at 6pm and concluded at 8am, however, it took a further 36 hours to bring in the casualties from the front lines. The method of carry used to bring in soldiers to the medical posts can be read as an indicator of the severity of the soldier's injury. An injured soldier with a femur fracture, an abdominal wound, or a major head injury would be a lying case, whereas a less severe head contusion, a broken arm, or lower leg fracture could sit on a transport. The least severe injuries still required medical treatment, but the soldier would make his own way to medical assistance by walking so as to enable medical personnel to assist soldiers with more significant injuries. Figure 2.2 shows a large number of lying cases being brought in by the Field Ambulance units 18-36 hours after the cessation of hostilities. Reading Figure 2.1 in concert with Figure 2.2 suggests that the 8AFA stretcher bearers were scouring No Man's Land for soldiers who were still alive but had been unreachable by medical units until that point and who were unable to make their own way to medical assistance. As shown in Figure 2.3, almost 80 per cent of the injuries sustained in the battle were injuries to the upper and lower limbs and head injuries. This is borne out by the proportion of soldiers brought in using each method of carry. Lying cases were 47 per cent of injuries, sitting were 26 per cent, and walking cases made up 27 per

²² Colonel AL Shepherd, War Diary 21 July 1916, 8th Australian Field Ambulance – July 1916, AWM: AWM4 26/51/6.

cent of casualties for the Battle of Fromelles.²³ With almost three quarters of casualties requiring some form of assisted evacuation it is not surprising that the AAMC was stretched to its limit and the men doing the physical work of evacuation were exhausted.

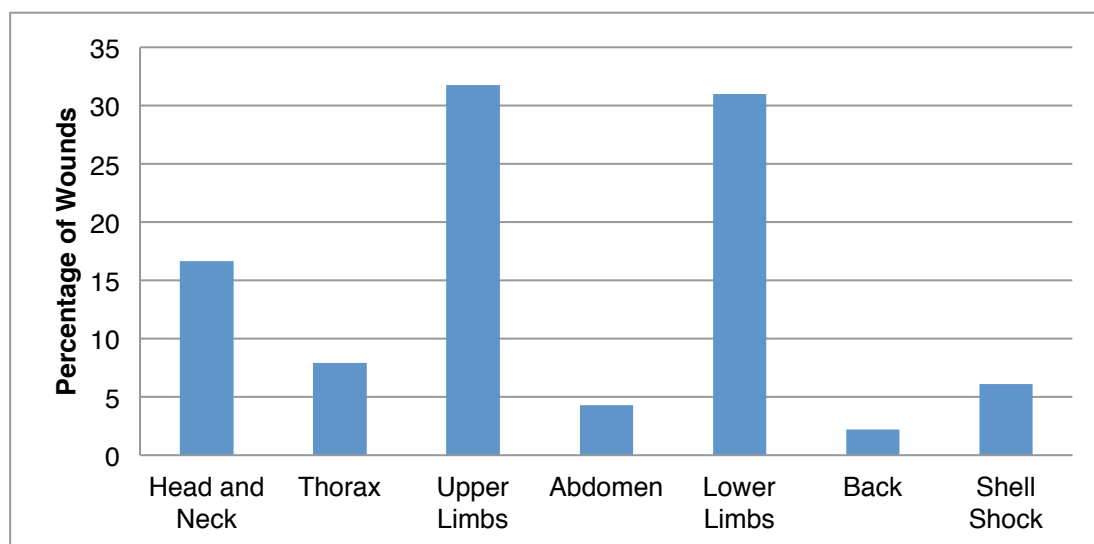


Figure 2.3: Wound type admitted to AFAs 19-20 July 1916 (as a percentage of total)²⁴

That the injured soldiers were able to walk to medical assistance did not always mean that they arrived at a medical unit with minor medical issues. Of the walking cases Captain Bullen wrote: “These present a difficult problem for satisfactory handling in that though often slightly wounded there is usually a certain amount of shock and many collapse at the ADS.”²⁵ The distance that the men had to walk to get to the Advanced Dressing Station (ADS) was substantial and whilst the provision of hot soup and coffee helped to alleviate the problem Bullen suggested alterations be made to the standard medical arrangements for future battles. He advised that establishing a depot around two thousand yards behind the trenches on the main evacuation lines would assist. Slightly wounded men could then walk to this depot, receive rudimentary treatment and sustenance and then be transported to the Main Dressing Station in motorised vehicles, thereby substantially cutting the distance that wounded men had to walk.

²³ Compiled from ‘Percentage Table Showing Location of Wounds of Casualties Admitted to Field Ambulances in Action 19th/20th July.’ War Diary Appendix 35, ADMS 5th Aust. Div. – July 1916, AWM: AWM4 26/22/6 Part 1.

²⁴ Compiled from ‘Percentage Table Showing Location of Wounds of Casualties Admitted to Field Ambulances in Action 19th/20th July.’ War Diary Appendix 35, ADMS 5th Aust. Div. – July 1916, AWM: AWM4 26/22/6 Part 1.

²⁵ Captain N Bullen, ‘Report on Work Done by Ambulance During Action of 19th, 20th, 21st July’, War Diary Appendix 22, 15th Australian Field Ambulance – July 1916, AWM: AWM4 26/58/3.

It was common at Fromelles for non-medical corps officers and men to be drawn into casualty clearance and evacuation and to be used for work that was not their responsibility. As mentioned above, the 8AFA deployed transport, batmen, dental, and office personnel in order to clear the wounded from the front to medical posts. Similarly, in the 15AFA area of operations, the men in the artillery helped in the physical work of the medical corps. Captain Bullen wrote: "Valuable assistance was given by the men of the Heavy Battery in unloading wagons and generally assisting our bearers."²⁶ The evacuation of casualties was hard physical work. Close to the front wounded soldiers were carried by stretcher bearers either on stretchers or occasionally a bearer would pick up a soldier and carry him without mechanical assistance. Once in an area where motorised transport was used to cross the terrain, the stretcher bearers were still required to lift and shift patients on and off transports and into position in the medical units. As noted above, Colonel Shepherd reported that those clearing casualties worked until completely exhausted. This battle, though one with a high casualty rate, was over in less than a day with all casualties collected in fifty hours from initial bombardment to the clearing of 'No Man's Land'. The ability of the Field Ambulance units to manage the workload of the men would become more significant in future battles once multiple divisions were used in military operations over extended periods of time.

Despite the medical services being prepared in advance of the commencement of hostilities they were still stretched once the battle started, and this was most evident in the problems with evacuation from the trenches. The scale of the casualties was unprecedented for such a short period of time and, while Captain Bullen acknowledged the success of the casualty evacuation from the ADS onward, he was more critical of the system from the trenches working back to the ADS. The 15AFA was reinforced by men from the 2/4 Battalion of the Oxfordshire & Buckinghamshire Light Infantry Regiment (Oxford Bucks), the 5th Sanitary Section and the New Zealand Army Medical Corps. By the time the last of these started working in the area some bearers in the 15AFA had been working continuously for 22 hours with Bullen describing them as "completely knocked out".²⁷ In the period from the commencement of battle to 5:30am on 20 July around 800 casualties

²⁶ Captain N Bullen, 'Report on Work Done by Ambulance During Action of 19th, 20th, 21st July', War Diary Appendix 22, 15th Australian Field Ambulance – July 1916, AWM: AWM4 26/58/3.

²⁷ Captain N Bullen, 'Report on Work Done by Ambulance During Action of 19th, 20th, 21st July', War Diary Appendix 22, 15th Australian Field Ambulance – July 1916, AWM: AWM4 26/58/3.

had been evacuated through Bullen's ADS by three Officers, seven Non-commissioned Officers (NCOs) and 75 men from the 15AFA and the Oxford Bucks. Bullen wrote:

Their work was rendered more difficult by the fact that the Regimental Service proved quite inadequate and soon broke down completely. The fact that plenty of work was found for the large number eventually engaged at this one Station shows the advisability of providing for such a rush of cases either by:

1. Increase of strength of Bearer Subdivision of Ambulances
2. Increase in strength of AMC details of Fighting Units
3. Obtaining details in advance from Reserve fighting units to stand by until required.²⁸

There were eventually 8 Officers, 16 NCOs and 143 Men evacuating casualties from the Regimental Aid Posts to the Advanced Dressing Station. This breakdown of casualty evacuation at the regimental level is supported by the war diaries of the 8AFA and 14AFA which show that Field Ambulance bearers were working right up to and in the trenches to clear injured soldiers. The breakdown at this level of the clearance chain is different to that found in the campaign at Gallipoli. In that instance evacuation to Regimental Aid Posts was relatively smooth but the breakdown occurred due to the inability of the AAMC to land its full complement of medical units on 25 April 1915. At Fromelles the evacuation from the ADS was relatively smooth, due in large part to good roads and motorised transport, but the work in the trenches failed.

The assessments by members of the AAMC of the medical arrangements for Fromelles provide insight into their priorities and problems in battle. They noted the significance of cooperation from non-medical units, both in sharing facilities and in the form of manpower to alleviate some of the physical strain casualty evacuation placed on the men of the Australian Field Ambulance. But they also highlighted the problems associated with locating the medical units a long way behind the lines especially for the walking wounded and the stretcher bearers clearing casualties from the front to Advanced Dressing Stations and Regimental Aid Posts. At Fromelles it is also possible to see the difference in procedure from the campaign at Gallipoli. The early and active inclusion of the medical corps in planning and the ability of the medical corps to prepare and refine procedure were vastly different to the lack of autonomy granted to Australian medical units in the Dardanelles Campaign. Historian Gary Sheffield argues that the attack damaged

²⁸ Captain N Bullen, 'Report on Work Done by Ambulance During Action of 19th, 20th, 21st July', War Diary Appendix 22, 15th Australian Field Ambulance – July 1916, AWM: AWM4 26/58/3.

British-Australian relations, however, as far as the medical services were concerned, the Battle of Fromelles was a step forward from their recent experience in Gallipoli.²⁹

The Battle of Pozières

As the events at Fromelles were unfolding, preparations were being made for an attack on the village of Pozières, which had tactical significance for the British Army. It was situated on top of the ridgeline that ran from Thiepval to Ginchy, and capturing it and the land around Mouquet Farm would enable the British Forces to observe the German positions around Thiepval from the rear. If the Fifth Army was able to capture Pozières it would be in a position to attack the German second line and it would also provide protection, in the case of a major British advance, to the flank of the Fourth Army.³⁰ The initial attack was undertaken by the 1st Australian Division on 23 July 1916. It secured the town of Pozières with 5286 casualties before the division was relieved by the 2nd Australian Division on 27 July. The 2nd Australian Division then expanded the territory held to include the land surrounding the village, sustaining 6800 casualties in the process, before being relieved by the 4th Australian Division on 6 August. This division remained in the line until the battle ended the following day after a final attack by the German Army.

The planning for the Battle of Pozières was generally methodical and sound. Despite urgency being advocated by Fifth Army commander General Hubert Gough and Sir Douglas Haig, commander of the British Expeditionary Force, the 1st Australian Division Commanding Officer, Major General Harold Walker, planned thoroughly for the attack and delayed the day of attack in order to ensure his troops were prepared for battle.³¹ The same cannot be said for the initial attack by the 2nd Australian Division. The first operation by this division, on 29 July, was described by Robin Prior and Trevor Wilson as a “fiasco”, though a fiasco the divisional staff learned from in order to plan for and execute a successful second attack on 4 August.³²

When I ANZAC Corps moved into the area around Pozières much of the medical infrastructure was already in place, which, combined with the landscape around Pozières, dictated the location of medical posts. However, unlike at Fromelles, the cooperative use of

²⁹ Gary Sheffield, *The Somme* (London: Cassell, 2003), 94.

³⁰ Robin Prior and Trevor Wilson, *The Somme* (New Haven: Yale University Press, 2006), 175.

³¹ Prior and Wilson, *The Somme*, 176.

³² Prior and Wilson, *The Somme*, 178–9.

buildings and the handing over of premises did not occur at Pozières, at least not to the 1st Australian Division. The Assistant Director of Medical Services (ADMS) for the 1st Australian Division, Colonel Alfred Hobart Sturdee, wrote in an appendix to his war diary:

In drawing up the original scheme for evacuation of the wounded much difficulty was encountered as none of the Main Dressing Stations, formerly used for the Area in which our troops were operating were handed over to us, also the Advanced Dressing Station at Becourt Chateau which from the lay of the ground and the formation of the roads was our natural clearing spot was outside our area. It was at first refused to us and then when we had occupied it we were instructed to vacate it upon the evening of July 22nd; as the vacation of this position on that evening would have completely upset all arrangements I reported the matter to the AA&QMG and received instructions from him and the AA&QMG of the Corps to continue its use.³³

In this instance the landscape was not sufficiently taken into account when drawing up areas of operation and Sturdee had to choose between hoping the soldiers under his care found their way to his unit instead of following the logical path to medical assistance, or else he could intervene to alter the arrangements. He chose the latter and this was a deliberate subversion of military hierarchy. When the flaws in the plan became obvious to Sturdee and he occupied the Advanced Dressing Station even though he had been ordered not to, he did so late enough before the commencement of the battle that to order him to move his unit would have created too high a risk for the AAMC and to the soldiers it served. As a result, the Assistant Adjutant and Quartermaster General (AA&QMG) had little choice but to accept the violation of military doctrine. There is no indication in his records of Sturdee facing disciplinary proceedings as a result of these actions and his concern that the logical place for the ADS was Becourt Chateau was validated by the clearance statistics.³⁴ Those statistics show that two thirds of the casualties for the 1st Australian Division passed through his ADS at Becourt Chateau.³⁵

Much like at Fromelles, distance was again a factor in the casualty evacuation process at Pozières. Sturdee wrote: “Our evacuations again were made difficult owing to the Main

³³ Colonel AH Sturdee, War Diary Appendix C, ADMS 1st Aust. Div. – July 1916, AWM: AWM4 26/18/20.

³⁴ Colonel AH Sturdee, Attestation Papers, National Archives of Australia (hereafter NAA): B2455/STURDEE ALFRED HOBART/8095734.

³⁵ Compiled from Lieutenant-Colonel HN Butler, War Diary 22 – 26 July 1916, 3rd Australian Field Ambulance – July 1916, AWM: AWM4 26/46/19.

Dressing Stations being so far removed from the scene of operations.”³⁶ Whilst this problem was largely resolved by the use of motorised transport, the co-opted transport units were not from the 1st Australian Division (1AD). The DDMS of the Corps gave the 1st Division use of the 2nd and 4th Australian Divisions’ motor ambulances as well as the motor lorries and buses of the 1st Australian Division Supply Company along with four lorries from the British 19th Division. This sharing of resources was beneficial for the purposes of casualty evacuation, but it was not just vehicles that were used from other units. Over the course of 1AD’s time in the line, officers and other ranks from 13AFA, 5AFA and 12AFA were added to the 1st Division’s usual complement of Field Ambulances (1AFA, 2AFA and 3AFA). These units were ordinarily attached to the 2nd and 4th Australian Divisions which then meant that medical units were on active duty more often than their corresponding fighting units.

Sturdee broke with military doctrine again in the way he organised the personnel of the Field Ambulances. Ordinarily each Field Ambulance had a tent subdivision and a bearer subdivision that worked together under one commanding officer to take care of one section of the evacuation chain. At Pozières, the tent subdivisions of 1AFA and 2AFA established two Main Dressing Stations (MDSs), one for stretcher and severe cases and one for slight and walking cases. The three bearer subdivisions as well as 3AFA’s tent subdivision were placed under the command of Lieutenant-Colonel Harry Nairn Butler of the 3AFA. Under Butler ADSs were established at North Chimney Albert and Becourt Chateau. The availability of motorised transport and decent roads meant that bearers were more useful closer to the front and, as at Fromelles, the AAMC bearers worked forward to reinforce the regimental bearers to facilitate casualty clearance from the trenches. This level of adaptability and flexibility in the deployment of medical personnel demonstrates that significant decision making responsibility had been handed over to Australian officers. In his report Colonel Sturdee wrote: “In conclusion I would like to add that owing to the good and willing work performed by all, the evacuation of the wounded surpassed my most sanguine expectation.”³⁷ The relative success of casualty evacuation with this new model of deployment for the Field Ambulance subdivisions would form the basis of further departures from established doctrine once the Australian forces were engaged at Messines in July 1917.

³⁶ Colonel AH Sturdee, Appendix C, War Diary, ADMS 1st Aust. Div. – July 1916, AWM: AWM4 26/18/20.

³⁷ Colonel AH Sturdee, Appendix C, War Diary, ADMS 1st Aust. Div. – July 1916, AWM: AWM4 26/18/20.

The groundwork was laid for another innovation that would come later at Messines once the 2nd Australian Division (2AD) relieved 1AD. Colonel Alfred Sutton, Assistant Director of Medical Services 2AD, took pains to ensure that injured soldiers were not being unnecessarily attended to. Sutton wrote to all Regimental Medical Officers:

In the event of heavy casualties RMOs and Medical Officers of Advanced Dressing Stations and Posts are reminded that the urgent necessity is to clear casualties to Main Dressing Station as rapidly as possible. A wound covered by a First Field Dressing and not bleeding will not be touched.³⁸

In order to avoid congestion all cases that could not be treated immediately were to be evacuated further back from the front so that the injured were not accumulating in areas exposed to enemy fire or blocking communication networks.³⁹ This was a lesson learned from Gallipoli where soldiers awaiting treatment accumulated on the beach around the 1st Australian Casualty Clearing Station and were thus vulnerable; some of those on the beach were subsequently injured or killed by shrapnel. The decision not to redress a wound already adequately dealt with for the purposes of evacuation and to push evacuation away from the front as quickly as possible were both ideas that were utilised to greater effect at Messines.

After the attack of 4 August, Colonel Sutton again reported that AAMC Bearers also assisted regimental bearers to clear casualties from the trenches during both the late July and early August operations. He wrote, echoing his counterparts from other divisions and previous battles:

The experience has shown the need for increase in number of Regimental Stretcher Bearers. Over and above the 16 men on the establishment another 16 men per Battalion should be available as a reinforcement. Stretcher Bearers cannot be provided from the Field Ambulances without materially delaying evacuation of the wounded further down the Line.⁴⁰

This problem of overwork for an insufficient number of bearers would continue beyond Pozières.

³⁸ Colonel A Sutton to RMOs 2AD, 2 August 1916, War Diary Appendix A, ADMS 2nd Aust. Div. – August 1916, AWM: AWM4 26/19/12.

³⁹ Colonel A Sutton to RMOs 2AD, 2 August 1916, War Diary Appendix A, ADMS 2nd Aust. Div. – August 1916, AWM: AWM4 26/19/12.

⁴⁰ Colonel A Sutton, 'Report on AAMC Operations in Attack on August 4th, 1916', War Diary Appendix G, ADMS 2nd Aust. Div. – August 1916, AWM: AWM4 26/19/12.

The Battle of Mouquet Farm

Unlike at Pozières where each division of I ANZAC was used in successive phases, at Mouquet Farm the three divisions were used simultaneously. From this battle there were 8,600 casualties with the majority (some 4,650) in the 4th Australian Division (4AD).⁴¹ The three battalions of 4AD were ordered to capture Mouquet Farm on 14 August. All three were much depleted and the results were disastrous. Prior and Wilson's damning assessment of the attack is telling. They write:

the melancholy fact is that the three battalions which were in no shape to attack at all suffered some 1,100 casualties for precisely no gain of ground. The husks of the three battalions had been reduced to a state of rebellion by the incompetence of their superiors. In truth the operation should never have taken place.⁴²

The Australian Divisions were pulled out of the line, much reduced in size from when they began the Battles of Pozières and Mouquet Farm, and the Canadian Corps was brought in to capture the objectives.

With the Battles of Pozières and Mouquet Farm effectively forming one longer Battle of Pozières Ridge it is not surprising that the same factors that were problematic for the Australian Army Medical Corps at Pozières were encountered again at Mouquet Farm. One such problem was the issue of distance. Despite the front moving forward from attacking Pozières to Mouquet Farm, a distance of around 1.7 kilometres, the Advanced Dressing Station was maintained at Becourt Chateau. The problems associated with having an Advanced Dressing Station well behind the front were then exacerbated by the front moving further forward. Colonel Sturdee, ADMS 1AD, decided against moving the ADS closer as it would endanger the Motor Ambulances that were evacuating soldiers from that point. As a result, the seriously wounded still had to be carried long distances placing greater strain on the stretcher bearers. In this instance, the bearers not only worked right up to the trenches but, in at least one case, a soldier was brought in from 'No Man's Land' by divisional bearers under the protection of a white flag.⁴³

⁴¹ Prior and Wilson, *The Somme*, 184.

⁴² Prior and Wilson, *The Somme*, 183.

⁴³ Colonel A Sturdee, War Diary Appendix B, ADMS 1st Aust. Div. – August 1916, AWM: AWM4 26/18/21; Also Colonel Shaw, 'Report on Operations from August 12th to August 21st 1916' War Diary Appendix 8, 1st Australian Field Ambulance – August 1916, AWM: AWM4 26/44/17.

The issue identified at Pozières of walking wounded not finding their way to aid posts was noted again by the medical men at Mouquet Farm. The logical path to evacuate from the area due to the lay of the land was not always the path required to reach the soldiers' respective medical units. The division of the terrain into divisional areas did not adequately take the landscape into account. Sturdee wrote:

Our collecting posts were so situated that most of the wounded came into our hands. A few found their way into a British Field Ambulance by taking a turn to the right at Pozières and so wending their way to O villiers a natural, but owing to the division of the area, a wrong course.⁴⁴

Solving this problem would require cooperation between divisions within a corps, as well as between corps and, at the extreme flanks of the front, potentially between the Armies of the British Expeditionary Force and its allies. As will be seen in the next chapter, the work of the various medical services in 1918 went some way toward achieving this.

At Mouquet Farm the AAMC improvised some of the medical arrangements in an attempt to limit the impact of the extended evacuation on casualties. In the 1st Australian Division Colonel Sturdee reported that during periods when casualties were light Colonel Shaw, Officer Commanding 1AFA, evacuated slightly wounded cases using ambulance wagons. This sped up the process and increased the level of comfort experienced by wounded soldiers. It would also have limited the number of cases who went into shock, as had been the case for many at Pozières. Once casualty numbers increased again the usual process of evacuation resumed. Sturdee pointed out yet again that the number of stretcher bearers was insufficient to cope with the demand. At the end of his report he wrote:

In conclusion I would like to point out that the number of bearers attached to a Division is at times too small to cope with the large number of casualties which occur in modern warfare. For this reason the various bearer divisions had to be grouped together and controlled more or less by the Corps, with the result that when the Divisions went into rest the bearers were still left at the front nominally in reserve but actually more or less at work.⁴⁵

This separation of bearer and tent subdivisions and placing the bearers under one command continued the practice established during the Battle of Pozières and would

⁴⁴ Colonel A Sturdee, War Diary Appendix B, ADMS 1st Aust. Div. – August 1916, AWM: AWM4 26/18/21; punctuation corrected to improve readability.

⁴⁵ Colonel A Sturdee, War Diary Appendix B, ADMS 1st Aust. Div. – August 1916, AWM: AWM4 26/18/21.

continue at Messines. In an environment where resources were limited it was important to use those available as efficiently as possible.

In Flanders' Fields: The Australian Army in 1917

I ANZAC was withdrawn from the line in early September 1916 from which time the Australian units were rebuilt and underwent further training before being used in the Battle of Bullecourt in April 1917. Some of the Australian Divisions did spend time during Winter 1916/1917 on the Somme and they faced significant medical problems in trench foot, frostbite, and influenza; however, the focus on this chapter is the evacuation of casualties during battle so these issues are not discussed here.⁴⁶ The main battles of 1917 to involve the Australian Imperial Force were the Battles of Messines and Passchendaele (also known as the Third Battle of Ypres), located just over the border in Belgium. For the Australian Army Medical Corps these battles consolidated Australian control of medical care for Australian soldiers and then challenged the idea of military primacy in decision-making, with doctors working in a manner more reminiscent of their civilian work than their military role.

Battle of Messines

Planning commenced for the Battle of Messines in January 1917 but the battle did not start until June of that year. Once objectives were identified the BEF began to put in place plans that required considerable preparation; they were able to do this as the front had not moved substantially for the best part of two years, and there was no indication of that changing. This led to significant tactical successes in pursuit of limited objectives for the combat operations including the innovative use of a creeping barrage, mined explosives under the German lines, and extensive artillery bombardment. Despite coming at a significant cost in terms of casualties, this battle was a turning point for both combat and medical operations. The institutional learning that occurred after Messines was by no means immediate or evenly distributed across the military – old mistakes would be repeated – but the successes and innovations would eventually be harnessed in order to win the war on the Western Front, the most significant theatre of war.⁴⁷

⁴⁶ See Butler, *The AAMS in the War of 1914-1918*, 1940 for further information.

⁴⁷ Gary Sheffield, "Finest Hour? British Forces on the Western Front in 1918: An Overview," in *1918 Year of Victory: The End of the Great War and the Shaping of Victory* (Wollombi, NSW: Exisle Publishing, 2010), 65; Aimée Fox-Godden, "Putting Knowledge in Power": Learning and Innovation in the British Army of the

In a report written after the war, Lieutenant-Colonel John Hubback Anderson,⁴⁸ who had been Deputy Assistant Director of Medical Service for the 3rd Australian Division, identified what were, to his knowledge, a number of “distinctive characteristics” of the Australian medical arrangements for Messines.⁴⁹ These characteristics were varied and included innovative treatments, the structure of the medical services along the evacuation route, as well as the deployment of personnel within that structure.

The first innovation discussed by Anderson was the use of Thomas Splints. These splints were the invention of Hugh Owen Thomas and his nephew Robert Jones and they came into widespread use in military medicine in 1916 after much protestation from London trained doctors.⁵⁰ Their ability to stabilise a limb was a significant factor in the reduction of the mortality rate for femur fractures in the British Army and markedly reducing the need for leg amputations.⁵¹ At a meeting of the 2nd Army Medical Society Major Sinclair of the Royal Army Medical Corps argued for the use of Thomas Splints in forward areas. Anderson, however, was sceptical about their use. He thought they would be too cumbersome to be effective in the trenches based upon his experience of using them during 1916 at Pozières where the splints were used as far forward as Advanced Dressing Stations. Mark Harrison noted that from the summer of 1916 medical staff were ordered to use the splints when appropriate and that their application was taught in the RAMC School of Instruction from October 1917 by which time splinting was routine in dressing stations.⁵² It was, however, not yet commonly done forward of dressing stations. In order to overcome his objections to using Thomas Splints in forward areas, Anderson carried out what he described as ‘experiments’ in the trenches using dummies. During these experiments the splints performed well and Anderson put this down to the quality of the trenches around Messines. Having overcome his initial objection to the use of the splints in the forward areas Anderson set about finding a way around his second objection: the difficulty of getting adequate supplies. In order to get sufficient supplies Anderson visited

First World War” (PhD Thesis, University of Birmingham, 2015), 11; with thanks to the author for allowing me to read and cite the embargoed thesis.

⁴⁸ Due to what appear to be transcription errors the DADMS 3AD during the Battle of Messines is variously listed as JH, JF, JA and JM Anderson in a range of sources. The DADMS 3AD at this time was John Hubback Anderson AAMC, NAA: B2455/ANDERSON J H/1977480.

⁴⁹ ‘Memo by Liet.-Col. JF [sic] Anderson CMG on Messines operations’, AWM: AWM41 40.

⁵⁰ Arthur G. Butler, *The Australian Army Medical Services in the War of 1914-1918: Problems and Services*, vol. 3 (Canberra: Australian War Memorial, 1943), 280.

⁵¹ Harrison, *The Medical War*, 101.

⁵² Harrison, *The Medical War*, 101.

as many Advanced Depots of Medical Stores as he could and collected a few splints from each in order to not drain one completely. These were then sent up to Regimental Aid Posts at the last minute with both Advanced and Main Dressing Stations carrying supplies as well. Each car that travelled to an ADS from a Main Dressing Station carried a couple of splints to re-supply the Regimental Aid Post. This system worked well and Anderson proudly boasted:

They proved a great boon and one, if not more, was actually applied in firing trench by an RMO taking it up from RAP to patient. Some time after, I heard personally from a visiting Surgeon that fract. femurs got down extra well.⁵³

This innovation was the result of the industry and ingenuity of the doctors involved. From the participation in the Second Army Medical Society to the experimentation and eventual implementation of the use of splints, this is an example of civilian medical training influencing military medical practice.

Part of the success of Thomas Splints in Messines was due to the well-planned and sound structure of casualty evacuation. The plans for casualty evacuation at Messines were laid down by Colonel White, ADMS of the 3rd Australian Division, on 21 May 1917, some seventeen days before the battle commenced.⁵⁴ This contrasts with Gallipoli where Howse had virtually no ability to make plans himself, and Pozières where the area occupied by the First Australian Division was so cramped that many of the best positions for medical units had already been taken by other army units so that the ADMS, Colonel Sturdee, had to negotiate with the British medical services and disobey orders in order to get access to evacuation routes.

As part of Colonel White's arrangements the three field ambulance units were used in an integrated fashion rather than as three discrete units. The area they worked was divided into three sections with each section under an ambulance Commanding Officer as can be seen in Figure 2.4. There was one Commanding Officer for the Regimental Aid Post through to, but not including, the Advanced Dressing Station, and another CO for the Advanced Dressing Station up to the Main Dressing Station. The third CO was in charge of the Main Dressing Station and the Collecting Point, which is the place the walking wounded made their way to and were then able to rest and receive treatment. A

⁵³ 'Memo by Liet.-Col. JF [sic] Anderson CMG on Messines operations', AWM: AWM41 40.

⁵⁴ MO Circular No. 1, 'Scheme of Evacuation of Wounded during MAGNUM OPUS', 21 May 1917, War Diary Appendix 3, ADMS 3rd Aust. Div. – July 1917, AWM: AWM4 26/20/8.

Field Ambulance consisted of Tent and Bearer Subdivisions and these distinctions were still relevant under White's plan. The subdivisions were allotted with bearer divisions to forward areas and tent subdivisions towards the rear. This is a logical distinction that allowed for stretcher bearers with extra training in carrying and manoeuvring casualties and applying first aid to be closer to the front and those whose training was focussed on assessment of injuries, re-dressing and the stopping of bleeding located further back. Under this system – an extension of the system used at Pozières and Mouquet Farm – each CO had part of each of the three field ambulance units under him. Normally one unit would be allocated a section of the line and Anderson wrote that this change was possible because of the method of training the Field Ambulances had received where they were trained together as a single body. Anderson wrote that the experiment had been partially tried at Pozières, “but it was more fully exploited at Messines”.⁵⁵ In these examples the Officers of the Australian Army Medical Corps were willing to depart from standard procedures when they saw an opportunity to function in a more efficient manner.

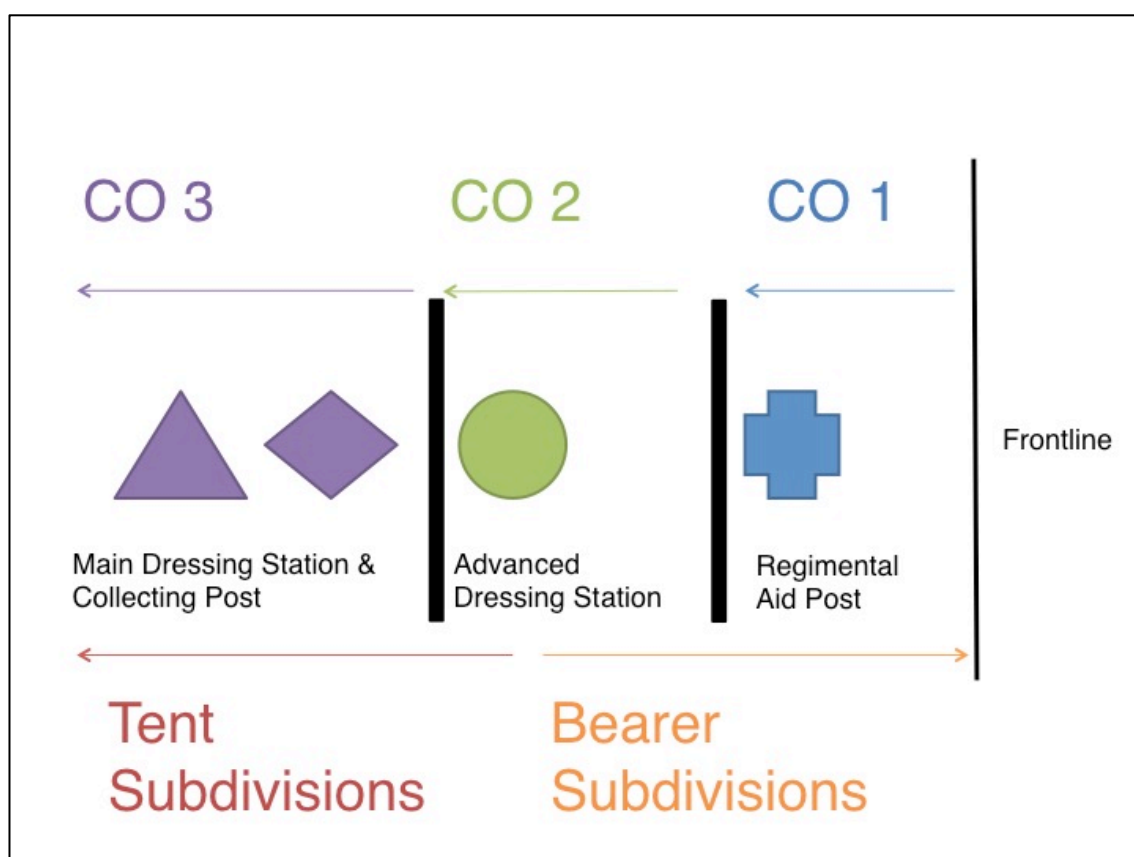


Figure 2.4: Diagram of AFA Areas of Responsibility for the Battle of Messines

⁵⁵ 'Memo by Liet.-Col. JF Anderson CMG [sic] on Messines operations', AWM: AWM41 40.

There were, however, instances where the AAMC changed its structure out of necessity rather than because of any perceived opportunity to increase efficiency. Much like Sturdee's 1st Australian Division at Pozzières, the 3rd Australian Division at Messines was functioning along a narrow front making it impossible to provide eight Regimental Aid Posts with sufficient protection from enemy fire, as was the ideal (see Figure 2.5). Having learnt from the problems at Pozzières where there were lots of Regimental Aid Posts feeding the vast majority of cases through one Advanced Dressing Station and creating a bottleneck (as in Figure 2.6), White placed two Regimental Medical Officers at each of four Regimental Aid Posts. Anderson commented: "the possibilities of the scheme were then seen and fully exploited as it was considered a good idea" (see Figure 2.7).⁵⁶

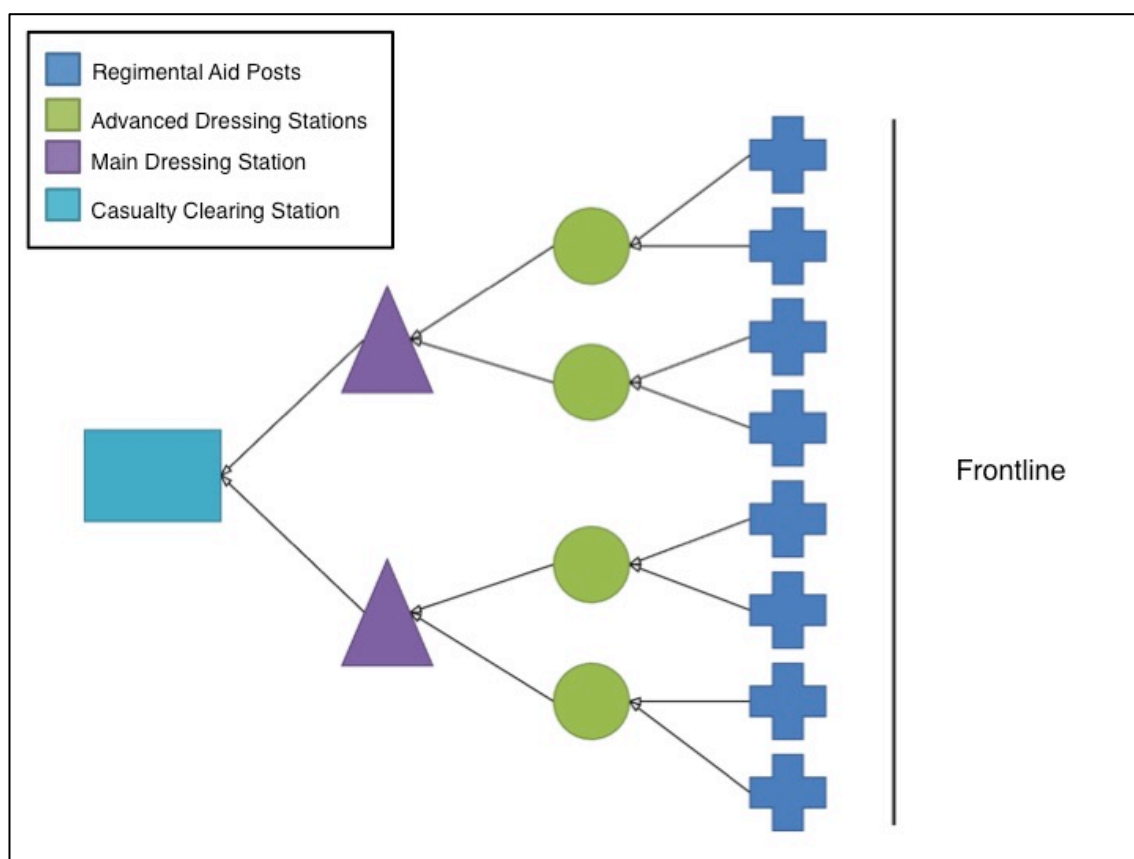


Figure 2.5: Ideal Deployment of AAMC Units with 8 RAPs

⁵⁶ 'Memo by Liet.-Col. JF Anderson CMG [sic] on Messines operations', AWM: AWM41 40.

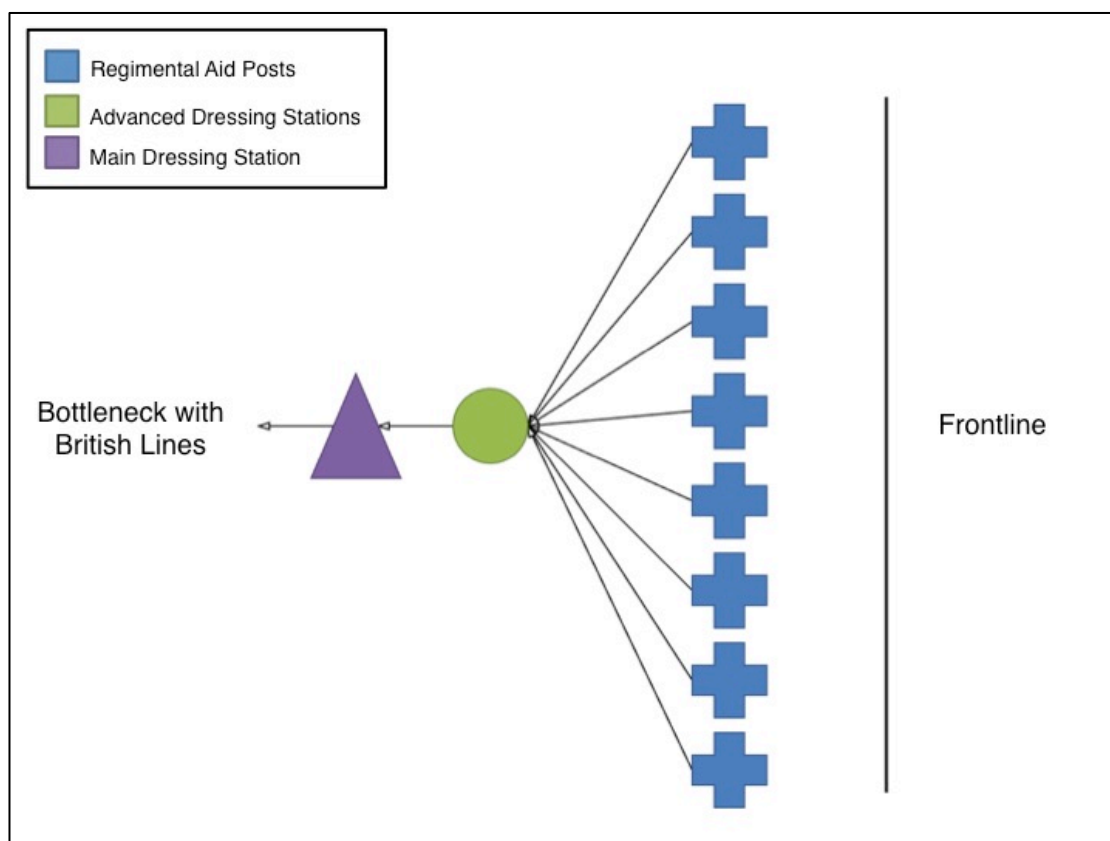


Figure 2.6: Diagram of AAMC Units for the Battle of Pozieres

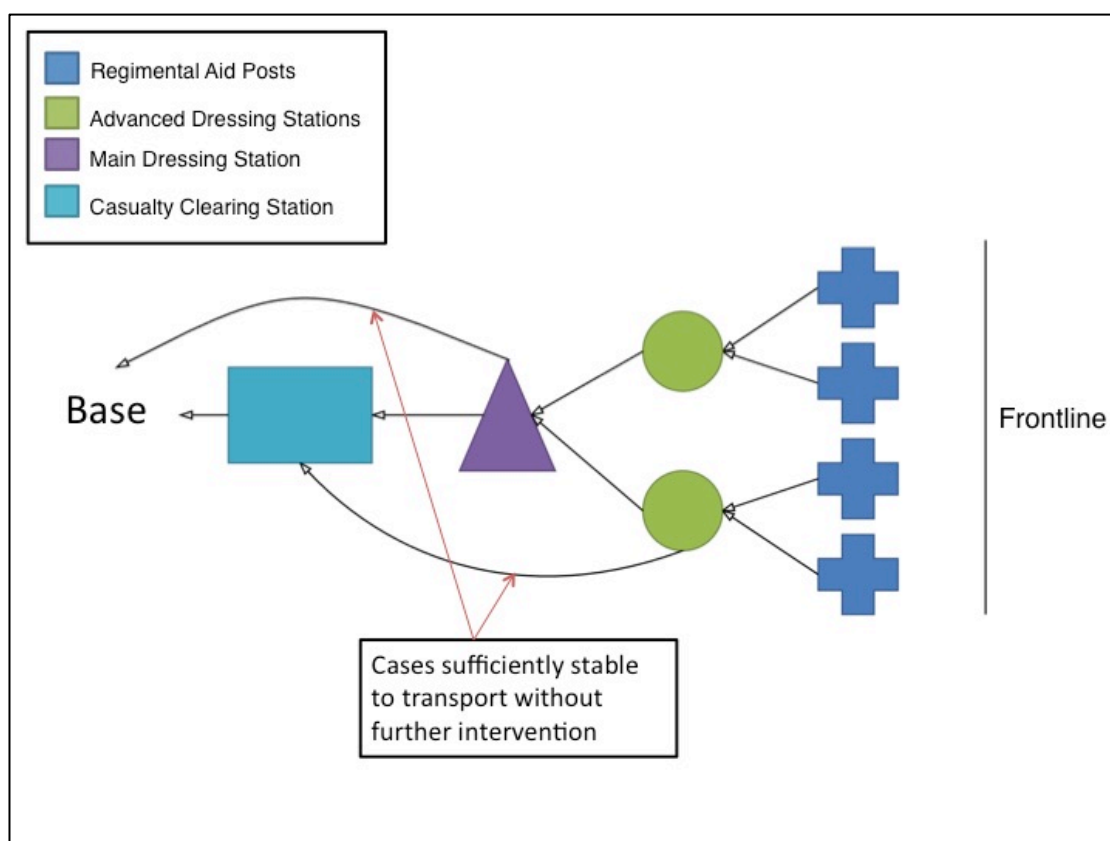


Figure 2.7: Diagram of Medical Arrangements for the Battle of Messines

This system, at Messines, had some significant benefits. First, the RMOs could work in shifts, which enabled them to get some rest, but during busy periods it was possible to have both at work therefore limiting the waiting time for wounded soldiers. Second, when the line advanced one RMO could establish a forward Regimental Aid Post that then evacuated casualties back to a well-known spot in the existing RAP rather than leaving it unattended in the advance. Third, when there was an emergency in the trenches, such as a major abdominal wound or severe injury to a senior Officer, and a Medical Officer was needed there, the RAP was not left unattended. Finally, in the event that one of the RMOs was injured, this move to halve the number of RAPs, and therefore double the number of staff at each, would enable the RAP to keep functioning under the command of the second RMO.

In his assessment of the medical arrangements for the Battle of Messines Lieutenant-Colonel Anderson noted a significant problem with this model – it created the possibility that the army could lose two Medical Officers if the RAP was hit with a large shell – which was not out of the realm of possibility, though it did not happen in this instance. Presumably if this had happened the nearest RAP would have been split in two with one half remaining in its original location and the second half taking over the location of the damaged RAP in much the same way as was laid out above in the case of an advance. In the Dardanelles Campaign, the structure of the medical evacuation was changed out of necessity, due to the failure of the combat units to reach their objectives and secure enough ground inland for the medical services to be fully deployed. In that instance, the plan had to be abandoned because the system laid down by the General Staff and the RAMC broke down completely. In the case of Messines, Colonel White knew ahead of the commencement of hostilities that he would have to contend with a limited area and so modified the structure to fit the specific circumstance faced by his Division.

Another change in the way Australian casualty evacuation functioned at Messines was, in Anderson's opinion, due to the proximity of the Casualty Clearing Station to the forward medical units, though in his report he adds "an Australian one at that" seemingly happy with the opportunities this afforded the 3rd Australian Division.⁵⁷ Anderson, together with the Commanding Officer of the Main Dressing Station went to see the Commanding Officer of the Casualty Clearing Station, Colonel Ramsay Webb. There they organised for cases appropriately marked at the Advance Dressing Station to bypass the Main Dressing

⁵⁷ 'Memo by Liet.-Col. JF Anderson CMG [sic] on Messines operations', AWM: AWM41 40.

Station and be cleared directly to the Casualty Clearing Station (Figure 2.7). They also put in place a similar procedure to evacuate casualties from the Main Dressing Station directly to the Base without needing to be seen at the Casualty Clearing Station. This would not have been possible if the Casualty Clearing Station was too far in the rear. Anderson wrote that he “got the idea from the Jap. arrangements as described in some book I read about the Russo-Jap war”.⁵⁸ This builds on the idea put forward by Sutton, then ADMS for the 2nd Australian Division, at Pozières when he ordered that casualties that were not bleeding and were adequately bandaged not be redressed at Advanced Dressing Stations in order to prevent congestion. By skipping stages in the casualty evacuation chain these medical men decreased the chances of congestion at the various medical stations and improved the experience of care for wounded soldiers.

Lieutenant-Colonel Anderson did not give an explicit reason for his enthusiasm for the Casualty Clearing Station in the evacuation chain being an Australian one. He did suggest that it was easy to make changes to procedure within divisional medical services (from the Advanced Dressing Station to the Main Dressing Station) and wrote “the having an Australian at the CCS made it possible for us”.⁵⁹ It is also possible that Anderson and Ramsay Webb knew each other in their civilian lives, given that both were practising medicine in Melbourne immediately prior to the war. I suggest he suspected an Australian Commanding Officer of an Australian Casualty Clearing Station would be more willing to depart from military doctrine in consultation with an Australian Deputy Assistant Directory of Medical Services (DADMS) than a British Officer would have been. Whatever his reasoning, it is significant that this is not a top-down order. Rather, it is an idea from a Divisional Officer shared with his immediate colleagues and then passed up the chain of command.

These changes had implications for the routes taken by the transports as they evacuated casualties and brought up supplies. At Pozières the same road was taken by the supplies being brought up to the front and the casualties being evacuated out. This added to the congestion and frequently meant that either supplies or casualties had to be prioritised as it was often impossible for both to happen simultaneously. At Messines the transports worked in circles and no roads overlapped. As a motor ambulance full of casualties arrived at the Main Dressing Station another one would set out from the other

⁵⁸ ‘Memo by Liet.-Col. JF Anderson CMG [*sic*] on Messines operations’, AWM: AWM41 40.

⁵⁹ ‘Memo by Liet.-Col. JF Anderson CMG [*sic*] on Messines operations’, AWM: AWM41 40.

side of the station so that there were always multiple ambulances moving to take up medical supplies such as splints and carry casualties back from the front. There was also a motor ambulance always on standby at the Advance Dressing Station as a contingency.

The work of the AAMC at Messines once again reinforces Mark Harrison's argument that a more consultative and inclusive culture existed on the Western Front than in the Dardanelles Campaign. Four days prior to the intended commencement of the Gallipoli landings no one from the medical services had been officially informed of, or involved in, the planning of medical arrangements. In contrast to this, Colonel White had enough information at his disposal to publish thorough plans for the medical evacuation of casualties two and a half weeks before the beginning of the Battle of Messines. Decisions about the evacuation of casualties on the Western Front were increasingly made on medical grounds and the medical services were increasingly involved earlier in the preparation for battle. Whilst it made sense for the efficiency of transport to send casualties through each stage in the clearance chain, it had negative consequences for the patient being evacuated. By skipping steps in the casualty evacuation chain and providing soldiers with a more direct route to medical assistance for complex issues, the medical services reduced the number of times the soldier needed to be transferred onto or off of a transport. This minimised the pain and trauma of being lifted and shifted, and decreased the amount of time it took to get to the destination as there was no need to stop at each stage of evacuation and have casualties re-sorted for transport to the next medical unit. The use of Thomas Splints in forward areas was seen as being in the best interest of the patient and so Anderson found a way to include them in casualty evacuation from Messines, and the experience at Pozières gave the Australian Army Medical Corps plenty of scope to reform the evacuation process in order to get patients to the appropriate medical care in a timely fashion.

By looking at Gallipoli, Pozières and Messines in this way it is evident that British involvement in Australian medical care in the First World War was gradually pushed further and further away from the front. The Dardanelles Campaign took place in 1915 but its effects ran through the First World War. As discussed in the previous chapter, Surgeon General Sir Neville Howse gave evidence to the Dardanelles Commission and declared that the medical arrangements "amounted to criminal negligence". He made that statement on 10 July 1917; that is, between the Battles of Messines and Passchendaele.⁶⁰ Howse told the

⁶⁰ Surgeon General Sir NR Howse, Evidence to Dardanelles Commission q. 27667, The National Archives (UK) (hereafter TNA): CAB 19/33.

Commission that he thought the Australian Army Medical Corps should be responsible for Australian casualties. He could do so with confidence having just seen the AAMC prove itself to be an appropriate provider of medical care for its soldiers.

A Strange Interlude: Further Attempts at Control

In what appears to be a strange choice in timing, during this period between the Battles of Messines and Passchendaele, discussions were held between Britain and her Dominions regarding the future of the Imperial medical services. This despite the fact that it was still 'fighting season' and plans were already in process for the Battle of Passchendaele. The apparent shift towards Australian control of Australian casualties was extended to include some level of Australian control of imperial medical services. On 4 September 1917, in the lead up to the Battle of Passchendaele, Major General Sir Alfred Keogh, Director General Army Medical Services, wrote to the administrative heads of the dominion medical services to advocate for a more integrated approach to medical care administration.⁶¹ Official Historian of the Australian Medical Services in the First World War, Colonel Arthur Graham Butler, states this was a result of a suggestion by Sir Neville Howse to Keogh.⁶² Keogh drew upon the shared heritage of the medical services, with those of Australia, Canada, and New Zealand having been modelled on the Royal Army Medical Corps, and noted that once the Dominion medical services began arriving for the First World War it became clear that they expected to maintain some level of autonomy. He lamented this in writing: "My own instincts were against this separatist tendency but it was obvious that any attempt on my part to weld all the Medical Services together for the common good would have been misunderstood and misinterpreted."⁶³ Keogh argued that the Empire did not receive the "full benefit" of its resources as they were being used in an inefficient manner during the war. He wrote that as a general rule the medical administrations of the Dominion armies "so far as they are individually concerned ... are of the opinion that the medical resources of the Empire should be pooled for the common object. It is, however, not probable that the political heads of their respective Governments would concur."⁶⁴ The proposed structure of this 'Empire Medical Service' advocated by Keogh acknowledged

⁶¹ Report by Major General Keogh to the Administrative Heads of Medical Services of Dominions, 4 September 1917, AWM: AWM25 481/367.

⁶² Butler, *The AAMS in the War of 1914-1918*, 1940, 2:823.

⁶³ Report by Major General Keogh to the Administrative Heads of Medical Services of Dominions, 4 September 1917, AWM: AWM25 481/367.

⁶⁴ Report by Major General Keogh to the Administrative Heads of Medical Services of Dominions, 4 September 1917, AWM: AWM25 481/367.

that the Dominions would not agree to their medical corps merging with and being subsumed by the Royal Army Medical Corps. Instead Keogh suggested the Dominion medical services have “a share in the control and management” of an “Imperial Medical Administration”.⁶⁵ His proposal would have entailed the medical corps remaining separate but combining their administrations thereby filling scientific, clinical and administrative posts based on merit without regard for the service to which the individual belonged. There would be one supply department and one Medical Headquarters in order to avoid unnecessary duplication of roles and minimise waste. Finally, Keogh wrote:

while the personnel of the several Medical Corps would as a matter of good administration be kept at work with the Fighting Troops of their respective Armies, they could in fact be available for all and every service which might be thought necessary.⁶⁶

These administrative changes were to be overseen by a medical council with the Dominion Medical Administrators attached to the War Office and equivalent to the Director General Army Medical Services. Keogh, clearly uncomfortable with his own proposal, wrote:

So far as I am personally concerned I have no objection, but as a firm believer in personal responsibility and a convinced opponent of Government by Committees, I consider this to be the weak point in the whole conception. I am not in the least anxious to evade my responsibilities, and would prefer to stand or fall by my own work, but the conclusion that the Dominions Medical Administrators must be equal to the DG, AMS is logical.⁶⁷

His final point in the proposed plan was to suggest that the Army Council should have the right to appoint representatives rather than leaving that issue in the hands of the respective Dominion governments. He wrote:

It should be remembered also that my impression as to the possible success of the scheme outlined above is derived rather from the knowledge I possess of the characters and abilities of the present D'sMS [*sic*] of the Dominions – their successors and my successor might not work so amicably – moreover to secure

⁶⁵ Report by Major General Keogh to the Administrative Heads of Medical Services of Dominions, 4 September 1917, AWM: AWM25 481/367.

⁶⁶ Report by Major General Keogh to the Administrative Heads of Medical Services of Dominions, 4 September 1917, AWM: AWM25 481/367.

⁶⁷ Report by Major General Keogh to the Administrative Heads of Medical Services of Dominions, 4 September 1917, AWM: AWM25 481/367.

the right men the appointments of the former could not be allowed to rest with the Dominions, but should be made by the Army Council.⁶⁸

This plan outlined by Keogh does not demonstrate much confidence in the governments of the Dominions. He states that he thinks he would have been misunderstood if he had advocated for his ideal structure for the medical services and then does not trust those governments to appoint appropriate replacements for their Directors of Medical Services should the need arise. In this way the imperial hierarchy was still on-going. While Keogh had accepted that the individuals working as the Directors of Medical Services for the Dominions were worthy of the position as his equal, he was not convinced the Dominion governments could make an appropriate choice a second time.

The Deputy Director of Medical Services and the Commanding Officer of the New Zealand Expeditionary Force, Colonel Parkes and Sir Alexander Godley, both responded to Keogh's memorandum, as did the Director of Medical Services of the Australian Imperial Force, Sir Neville Howse.⁶⁹ Parkes and Godley were in agreement with the reasoning in Keogh's plan but disagreed with him on the committee structure. Parkes wrote to Keogh:

The real difficulty and one which is likely to meet with much opposition by the Higher Command, is the question of equal representation on a Council with yourself by the Overseas Dominions. It is quite possible that a deadlock might arise in matters where the opinions of the representatives are equally opposed, perhaps on a question not directly concerning the Dominions, and although this may be a remote chance it is a contingency which might occur.⁷⁰

To remedy this problem Parkes proposed that the Directors of Medical Services for the Dominions take up positions similar to that of Staff or Executive Officers to the Director General and advise him with the Director General, i.e. Sir Alfred Keogh, the one to make decisions. Though Sir Alexander Godley was not originally included in the correspondence by Keogh, Parkes showed him both the letter from Keogh and his response. Godley wrote to Keogh in support of Parkes' suggestion that the Directors of Medical Services act as an

⁶⁸ Report by Major General Keogh to the Administrative Heads of Medical Services of Dominions, 4 September 1917, AWM: AWM25 481/367.

⁶⁹ The response of the New Zealand and Australian representatives is included in the same archive file at the Australian War Memorial as the memorandum from Keogh, however, any Canadian response that may have been written has not been located.

⁷⁰ Colonel Parkes, DDMS NZEF to Sir Alfred Keogh, DGAMS War Office, 14 September 1917, AWM: AWM25 481/367.

advisory council of Staff Officers.⁷¹ Sir Neville Howse was opposed to this alteration. Having discussed the issue with the Directors of Medical Services of Canada and New Zealand he responded to Keogh:

I have carefully considered the clear and concise principles enunciated by you and assuming that I am correct in thinking a Medical Council would be of assistance to the empire and admitting this presumption, I cannot see any logical solution of the question unless each member of the council had an equal share and responsibility in the administration of the Medical Service of the Empire.⁷²

This suggestion is in agreement with Keogh's original plan and would have allowed the Australian medical services to have a more direct say in the administration of the medical care provided to Australian soldiers, but it was in direct opposition to the position advocated by Parkes and Godley – a disagreement that did not bode well for a group contemplating embarking on a mission of management by committee. Howse's reason for opposing the position of Parkes and Godley was that the war was simply too big for one person to hold responsibility for a service of fundamental importance such as the medical corps. He wrote:

I am a strong believer in personal responsibility, but might I respectfully suggest that the War has become so vast and carried on under such varied conditions that it has become practically impossible for any one man to effectively control the Medical Services.⁷³

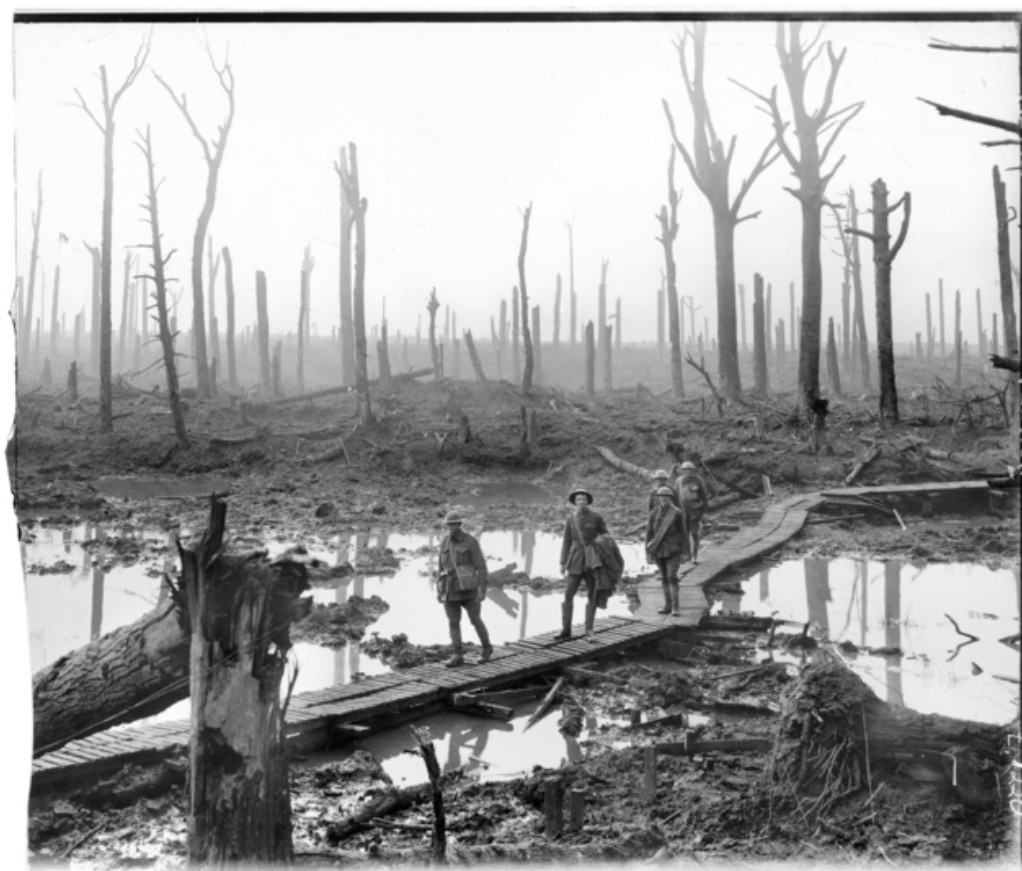
Whether as a result of this disagreement between the potential committee members or the opposition of the various governments to give up some level of autonomy, the administrations of the Empire medical services were not amalgamated.

⁷¹ General Sir A Godley, CO NZEF to Surgeon General Sir A Keogh, DGAMS War Office, 17 September 1917, AWM: AWM25 481/367.

⁷² Surgeon General Sir NR Howse, DMS AIF to Surgeon General Sir A Keogh, DGAMS War Office, 28 September 1917, AWM: AWM25 481/367.

⁷³ Surgeon General Sir NR Howse, DMS AIF to Surgeon General Sir A Keogh, DGAMS War Office, 28 September 1917, AWM: AWM25 481/367.

Battle of Passchendaele (Third Battle of Ypres)



AUSTRALIAN WAR MEMORIAL

E01220

Figure 2.8: Five members of a field artillery brigade, Chateau Wood, October 1917⁷⁴

The medical plans made for the Battle of Passchendaele were not substantially different from those for the Battle of Messines so do not need to be recounted here. Yet, casualty evacuation at the Battle of Passchendaele was particularly difficult. While the initial fighting was undertaken in fine weather, heavy rains between the subsidiary Battles of Broodseinde, on 4 October 1917, and Poelcappelle, on 9 October 1917, turned the ground to mud that was ankle deep in most places but knee or waist deep in others. This caused major problems for the stretcher bearers who had to trudge through the mud to evacuate casualties. Though duckboards were laid to help mitigate the problem of the mud – providing one of the most striking images of the war (see Figure 2.8) – they were not initially available, were often only in single file, and were sometimes damaged by the use of animal-drawn and motorised transports.⁷⁵ The distance between the Regimental Aid Posts

⁷⁴ Photograph by Frank Hurley, AWM: E01220.

⁷⁵ Lieutenant AH Moseley, OC 6AFA to Colonel Shepherd, ADMS 2AD, 13 October 1917, War Diary Appendix A, ADMS 2nd Aust. Div. – October 1917, AWM: AWM4 26/19/22.

and the Advanced Dressing Station was such that it was unexceptional for it to take six stretcher bearers five hours to carry one wounded soldier.⁷⁶ Frequently this was increased to eight, ten, or, in at least one case when it was particularly muddy, twelve stretcher bearers per wounded soldier.⁷⁷ This was a significant use of resources and once the bearers had handed over their casualty they were to make their way back to the front carrying replacement stretchers and other medical stores with them.⁷⁸ The Assistant Director of Medical Services for every Australian Division wrote in his war diary of the long shifts, under-resourcing, and utter exhaustion of the stretcher bearers of the Australian Field Ambulance during the Battle of Passchendaele.⁷⁹ And it came without any substantial gain in territory, with Prior and Wilson stating: “In all, the campaign probably reduced the strength of the BEF by the equivalent of 10 to 12 divisions out of a total strength of 60. No significant accessions of territory were made as a result.”⁸⁰

The medical arrangements for the Battle of Passchendaele extended the changes to military doctrine that had developed after the Battle of Messines. They provided for a process of directly evacuating wounded soldiers from the Advanced Dressing Station to the Casualty Clearing Station, skipping the Main Dressing Station when possible. The arrangements also made changes to the record keeping with the abolition of all medical record keeping other than Field Medical Cards. On 23 September Major JB Metcalfe on behalf of Colonel Manifold, Deputy Director of Medical Services I ANZAC, wrote to the Director of Medical Services for the 2nd Army to query the efficacy of the process.⁸¹ The DMS Second Army requested the information from the Commanding Officers of the

⁷⁶ ‘Report on Medical Aspect of Operations extending from 1st October to 18th October 1917’, War Diary Appendix 25, DDMS II ANZAC – October 1917, AWM: AWM4 26/16/19.

⁷⁷ Lieutenant AH Moseley, OC 6AFA to Colonel Shepherd, ADMS 2AD, 13 October 1917, War Diary Appendix A, ADMS 2nd Aust. Div. – October 1917, AWM: AWM4 26/19/22.

⁷⁸ Colonel RB Huxtable, ADMS 1AD to DDMS I ANZAC, ‘Medical Arrangements First Australian Division’ 28 September 1917, War Diary Appendix 8, ADMS 1st Aust. Div. – September 1917, AWM: AWM4 26/18/34.

⁷⁹ Colonel RB Huxtable, ADMS 1AD to DDMS I ANZAC, ‘Medical Arrangements During Recent Operations’, 28 September 1917, War Diary Appendix 8, ADMS 1st Aust. Div. – September 1917, AWM: AWM4 26/18/34. Major EL Hutchinson, ADMS 2AD ‘Forward Evacuation of Wounded (2nd Australian Divisional Area)’ 13 October 1917, War Diary Appendix A, ADMS 2nd Aust. Div. – October 1917, AWM: AWM4 26/19/22; ADMS 3AD ‘Report on Evacuation of Wounded from Sector held by Third Australian Division during Operations 11th to 21st October’ 25 October 1917, War Diary Appendix 13, ADMS 3rd Aust. Div. – October 1917, AWM: AWM4 26/20/13; Colonel Barber, ADMS 4AD, ‘Recommendations’ 20 October 1917, War Diary Appendix 17, ADMS 4th Aust. Div. – October 1917, AWM: AWM4 26/21/17.

⁸⁰ Robin Prior and Trevor Wilson, *Passchendaele: The Untold Story* (Melbourne: Scribe, 2002), 195.

⁸¹ Major JB Metcalfe for Colonel DDMS I ANZAC to DMS Second Army, 23 September 1917, War Diary Appendix, DDMS I ANZAC – October 1917, AWM: AWM4 26/15/21.

various Casualty Clearing Stations and their response was overwhelmingly positive.⁸² Lieutenant-Colonel R. Blanchard, Officer Commanding the 3rd Canadian Casualty Clearing Station, wrote:

I beg to report that there has been no difficulty in carrying out the new method in the case of the walking wounded with the assistance of the staff supplied by the Field Ambulances. The lying wounded have, with few exceptions, come with Field Medical Cards as before and this has relieved us of considerable extra work and inconvenience. Both walking and lying wounded have arrived here with wounds practically as well dressed as ever before.⁸³

As well as making some suggestions to refine the procedures for managing influxes of walking wounded, the Officer Commanding the 2nd Canadian Casualty Clearing Station replied: “so far as my observations go the scheme has worked very satisfactorily especially from the standpoint of the welfare of the patients.”⁸⁴ Lieutenant-Colonel Warmott CO of the British 10th Casualty Clearing Station suggested further refinements to the system. He suggested that Field Medical Cards be filled out for all patients at the ADS as the process of not completing them until they reached a CCS created considerable delay as “every case [had] to be redressed for diagnostic purposes only, whereas many of these cases could go straight on to train without being redressed.”⁸⁵ With these developments the principle of casualty evacuation prior to the Battles of Pozières and Messines had been largely eroded. The aim had been to keep wounded soldiers as close to the front as possible so they could be returned to their units and resume their place in the fighting force without too much delay. This principle was unrealistic in modern warfare given the unprecedented scale of the casualties. In the First World War, on the Western Front, it soon became apparent that casualties needed to be cleared as quickly as possible away from the lines in order to prevent congestion at medical posts and to avoid placing an unnecessary burden on the AAMC.

⁸² DMS Second Army to Officers Commanding British 10th & 17th and 2nd and 3rd Canadian Casualty Clearing Stations, 24 September 1917, War Diary Appendix, DDMS I ANZAC – October 1917, AWM: AWM4 26/15/21.

⁸³ Lieutenant-Colonel Blanchard, OC 3rd Canadian CCS to DMS Second Army, 25 September 1917, War Diary Appendix, DDMS I ANZAC – October 1917, AWM: AWM4 26/15/21.

⁸⁴ Lieutenant-Colonel Davey, OC 2nd Canadian CCS to DMS Second Army, War Diary Appendix, DDMS I ANZAC – October 1917, AWM: AWM4 26/15/21.

⁸⁵ Lieutenant-Colonel Warmott RAMC, OC 10CCS to DMS Second Army, 25 September 1917, War Diary Appendix, DDMS I ANZAC – October 1917, AWM: AWM4 26/15/21.

Conclusion

The men of the Australian Army Medical Corps challenged the traditional hierarchies in place over the course of 1916 and 1917. The imperial hierarchy that fostered Australian deference to Britain had already been disrupted by the end of the Dardanelles Campaign and Neville Howse was clear in his determination to maintain Australian control of Australian medical arrangements as far as was possible. Consequently, other hierarchies were challenged. Whereas in the British Army the medical corps was an important, if subordinate, part of the military, the small number of AAMC officers before the war meant that the AAMC was almost entirely dependent on civilian doctors. The dominance of these men in the AAMC influenced the way in which it solved problems. These medical men sought each other out and discussed solutions before informing their superiors of substantial changes to military doctrine, as was demonstrated by the changes they made to the casualty evacuation systems for the Battles of Pozières and Messines. These changes were built on and extended over the course of these two years of stationary warfare. What started with an attempt to prevent the unnecessary redressing of wounds at the Battle of Pozières developed into a sophisticated system of casualty evacuation that allowed for the rapid removal of casualties from the fighting area to the point of treatment, without unnecessary stops at medical posts along the way. While Lieutenant Colonel Anderson suggested that having an Australian Casualty Clearing Station at Trois Arbes to receive Australian casualties from the Battle of Messines allowed for the development of this process, the move to Flanders enabled the sharing of these ideas with the British and Canadian medical services through their Casualty Clearing Stations at the Battle of Passchendaele. By examining the changes in medical evacuation on the Western Front it is possible to see not just that decisions were increasingly made by medical men but that Australian civilian medical men influenced the process of casualty evacuation beyond the Australian Army Medical Corps.

Chapter Three

“We are now able to stand on our own bottom”: The AAMC and the Australian Corps in Mobile Warfare

The European winter of 1917/1918 was one of change for the Australian Imperial Force. By this time, in Australia, two plebiscites to introduce conscription had failed and the plans to raise a sixth Australian Division were scrapped. Those already recruited were distributed among the existing five divisions, which had suffered significant losses in the fighting in September and October 1917 during the Battle of Passchendaele. In November 1917, having been withdrawn from the line the month before, the five Australian divisions were reorganised into one Australian Corps and attached to the British Fourth Army. The British and New Zealand Divisions, which had been part of II ANZAC, became the British XXII Corps, part of the First Army. General William Birdwood who had been the Commanding Officer of I ANZAC was originally put in charge of the new Corps but, in May 1918, was made Commanding Officer of Fifth Army. As a result, Major General John Monash was promoted to Lieutenant General and the Australian Corps was in his command from May onwards, marking the first time an Australian was in command of a fighting unit at corps level.

This chapter picks up the lines of inquiry from the previous chapter and continues to examine the evacuation of casualties by the Australian Army Medical Corps (AAMC), this time focussing on the work of Australian medical men in 1918. The conditions of war were different to those found in 1916 and 1917. Butler argued in the Official History that the changes made in the way casualty evacuation was handled at Divisional and Corps level in 1918 were “a natural and simple adjustment” that “was accomplished with a smoothness which in some measure masks its significance”.¹ While I agree that the biggest changes had occurred as a result of Gallipoli and before Messines, in 1918 there were refinements to the processes used in 1916 and 1917 due to the changed circumstances of the war. The changes were significant not because they presented a drastic departure from the systems that were successful, but because they required the Australian medical services to retreat

¹ Arthur G. Butler, *The Australian Army Medical Services in the War of 1914-1918: The Western Front*, vol. 2 (Canberra: Australian War Memorial, 1940), 604.

from some of the innovations made to the casualty clearance process in the previous years. During 1916 and 1917 the Western Front did not move significantly despite the massive loss of life on both sides of No Man's Land. However, 1918 was notable for the relative movement in the lines. The German Spring Offensive of March and April made sweeping gains, especially early in the campaign, but the German army was soon beyond the reach of its supply lines and was then pushed back by the Allied forces, now supplemented by the arrival of the American Expeditionary Force. In what became known as the Hundred Days Offensive, the Allies reclaimed much of the territory that had been in German hands since 1914 and had almost cleared the German army from France before the fighting stopped with the Armistice at 11am on 11 November 1918. Of 1918 Mark Harrison noted that:

In casualty disposal, as in other areas, flexibility was the order of the day, as medical services attempted to keep pace with a rapidly advancing army. This was no easy task at the best of times but casualties were often heavy and the number requiring evacuation large.²

Harrison focused his attention on Royal Army Medical Corps (RAMC) Casualty Clearing Stations (CCSs) and the 'leap-frogging' movement of those units. By focussing on the divisional sectors this chapter demonstrates that the same principles were also used by the AAMC for the movement of Advanced Dressing Stations (ADSs) and Main Dressing Stations (MDSs).

After a discussion of Neville Howse's agitation for the creation of the Australian Corps, this chapter examines the preparations for the commencement of the 'fighting season' as well as the work of the AAMC during the German Spring Offensive in March and April. During this period the Australians, along with the rest of the Allies, were under sustained attack and were required to defend territory and sometimes hastily retreat, a military action that was problematic for a medical corps whose casualty clearance and evacuation systems had developed behind a relatively stable front line. This is followed by a discussion of the problem posed by influenza and an analysis of the broader context in which the AAMC worked in the second half of 1918. The chapter then explores the Battle of Hamel on 4 July, often seen as a turning point in the combat history of the war as it was the first all-arms battle with the integrated use of tanks, aircraft, artillery, and machine guns. I analyse the battle from the perspective of the medical administration to evaluate the integration of non-fighting units into the military machine and then move on to the

² Mark Harrison, *The Medical War: British Military Medicine in the First World War* (Oxford: Oxford University Press, 2010), 87.

Hundred Days Offensive and highlight the development of new casualty evacuation processes in the final months of the war as well as the untangling of Field Ambulances that had been working under one command in previous operations. Finally I discuss the innovative development of Divisional Resuscitation Teams in the AAMC, despite opposition from members of the RAMC.

This chapter argues that containment of the AAMC to one Corps enabled the Australian medical men to implement policies and procedures that were not present in other Corps, but that this also meant that when the type of warfare changed the AAMC had to retreat from some of the alterations made to casualty evacuation procedures in the stationary warfare of 1916 and 1917. By mid-1918 members of the AAMC occupied roles from the Deputy Director of Medical Services (DDMS) for the Corps right through to Regimental Medical Officers (RMOs). They were still responsible to the Director of Medical Services (DMS) for the Fourth Army, who was British, but all medical decisions from corps level down were made by Australian medical men. With the creation of the Australian Corps the vast majority of medical care at divisional and corps level provided to Australian soldiers was given by those enlisted in the AAMC. The structure of medical care for Australian soldiers in 1918 was the practical expression of Surgeon General Sir Neville Howse's desire to see the AAMC have control over the care provided to Australian soldiers.

“We should have made our officers competent”: Creating an Australian Corps

The Director of Medical Services for the AIF, Surgeon-General Sir Neville Howse, was one of those who advocated for an Australian Corps. On 20 July 1917, ten days after Howse gave his controversial evidence at the Dardanelles Commission, he wrote to the influential Major General Cyril Brudenell Bingham White, Chief of Staff to General Birdwood. In the letter he first outlined to White what had transpired during his testimony. Howse wrote:

Dardanelles Commission gave me 2.5 hours and were very surprised at my statements. (a) That I considered the medical arrangements so inadequate that the Officers responsible were in my opinion guilty of criminal negligence. (b) That I would strongly urge my Government in future under no consideration

to accept the assurance of the Imperial Government that adequate arrangements had been made for the care of our sick and wounded.³

He then directly linked the failure of the medical arrangements at Gallipoli to his argument for an Australian Corps by continuing in the same letter:

I want to tell you that a very strong feeling exists, and is spreading amongst the AIF that we should have an Australian Corps, and that our Chief should be called upon to state the number of Imperial Officers now employed with the AIF who, in his opinion, cannot be replaced by AIF Officers.⁴

Not only did Howse want to create an Australian Corps, uniting AIF units under one command, he wanted to remove as many British Officers as possible from positions within that Corps. He suggested to White that all but four or five Imperial Officers could be redeployed by the War Office to provide space for the promotion of AIF Officers. He wrote: "I heard an Officer who is not an aggressive Australian say that beyond General Birdwood, General Napier, and two or three General Staff Officers every Imperial Officer could be replaced without diminishing the efficiency of our Force."⁵ Of the men working in the AAMC, this meant assessing whether Colonel Courtenay Clarke Manifold, who was at that time the Deputy Director of Medical Services (DDMS) for I ANZAC, should remain in his position or be replaced by an Australian.

Howse was conscious of the significance of removing an Officer who had served the AIF well from an important position without cause. Yet that was not enough to stop him advocating for Manifold's replacement. He wrote:

I know the very grave discontent that exists among our Corps against the retention of Colonel Manifold; not on personal grounds, but because they feel it is reflective upon the Corps, and I must honestly say that I think the time has arrived when he should be replaced by an AIF officer. When Manifold was appointed, we had not an Officer competent to fill the position of DDMS, but that day is gone and we are now able to stand on our own bottom. I know it looks a rotten thing to even discuss the question of replacing Imperial Officers who have done us well, but we cannot overlook the fact that we are now nearly

³ Surgeon General Sir NR Howse to Major General CBB White, 20 July 1917, Australian War Memorial (hereafter AWM): 2DRL/1351, Item 2.

⁴ Surgeon General Sir NR Howse to Major General CBB White, 20 July 1917, AWM: 2DRL/1351, Item 2.

⁵ Surgeon General Sir NR Howse to Major General CBB White, 20 July 1917, AWM: 2DRL/1351, Item 2.

3 years at War, and we should have made our Officers competent during that period.⁶

One of the criticisms levelled at the Australians after Gallipoli was that they did not have enough trained Officers with a military mind-set who could be promoted to positions of command.⁷ Howse argued that nearly three years of war was enough to develop the skills and thinking necessary to assume those positions and fulfil their duties well and it was three and a half months after this letter was written that the Australian Corps was created. Colonel Manifold was not removed from the command hierarchy in the new Corps, rather he was made DDMS for the Australian Corps, the equivalent position to the one he held in I ANZAC. However, on 9 April 1918, another five months further on, he was replaced as DDMS Australian Corps by Colonel George Walter Barber, who had migrated to Australia in 1895 and enlisted in the AIF in 1914.⁸ After vacating his position with the Australian Corps Manifold returned to his previous duties with the Indian Medical Services.

“The only corps”: Australians Ahead of the Curve?

The doctors of the Australian Army Medical Corps were aware during the war that they had put in place systems not used elsewhere in the Allies’ medical services. On 18 February 1918 Colonel Manifold recorded in his War Diary that he went to a conference at the Fourth Army’s Headquarters along with all Deputy and Assistant Directors of Medical Services (DDsMS, ADsMS) working under the aegis of the Fourth Army. It was presided over by the Deputy Adjutant and Quartermaster General (DAQMG) under whose jurisdiction the medical services fell. Manifold recorded three issues that had been discussed: venereal disease, the creation of an Army School, and the elimination of Main Dressing Stations (MDSs). The details of the methods used to prevent and treat venereal disease will be discussed in greater detail in the final chapter of this thesis; however, it is worth noting at this point that Manifold recorded in his diary that the Australian Corps was “the only Corps which had regimental arrangements for preventive treatment for men returning from large towns and also arrangements for this in towns near the troops”.⁹

⁶ Surgeon General Sir NR Howse to Major General CBB White, 20 July 1917, AWM: 2DRL/1351, Item 2.

⁷ See Sir Ian Hamilton’s letter to Governor General of Australia, Ronald Munro-Ferguson, as discussed on page 36 of Chapter 1.

⁸ George Walter Barber, Attestation Papers, National Archives of Australia (hereafter NAA): B2455/BARBER G W/3048743.

⁹ Colonel CC Manifold, War Diary 18 February 1918, DDMS Australian Corps – February 1918, AWM: AWM4 26/17/2.

Regarding the second topic of discussion, Manifold wrote: “An army school for medical Officers was discussed and again we were found to be the only Corps which had had a School during the winter.”¹⁰ This army school was intended for Medical Officers and was approved by the Corps Commander on 10 January 1918.¹¹ Its purpose was “to provide to junior officers of the medical service essential knowledge of military organisation and special military medical subjects as will enable them more efficiently to carry out their duties to the service”.¹² The school went for eight days with a written examination on the morning of the ninth day and it included general military topics such as military law, map reading and field sketching, and pay duties, as well as medical topics including demonstrations on shock and medical and surgical equipment, visits to a Casualty Clearing Station (CCS) and baths and laundries. It also incorporated lectures on the care of soldiers’ health, the evacuation of wounded, water supply and chlorination, as well as sanitation in the field, the duties of a Medical Officer in active operations, the use of Thomas Splints and the treatment of Trench Foot.¹³ This school was a way of bridging the gap between the civilian medical training and experience of the Medical Officers and the military context in which they were practising medicine. For many of the Regimental Medical Officers in the AIF at this point of the war, battlefield medicine in war was their first experience of medical practice. The three medical schools in Australia, at the Universities of Sydney, Melbourne and Adelaide, had, at the request of the army, fast-tracked the medical education of many later-year medical students in order to help fill both the needs of the army in war and the civilian population of Australia, many of whose medical practitioners had enlisted in the AAMC and were serving either overseas or in Australia.¹⁴

The final issue discussed at the 18 February conference – the elimination of MDSs – was of particular relevance to the development of casualty clearance and evacuation processes in the First World War. On this topic Manifold wrote: “Central registration and

¹⁰ Colonel CC Manifold, War Diary 18 February 1918, DDMS Australian Corps – February 1918, AWM: AWM4 26/17/2.

¹¹ Colonel CC Manifold, War Diary 10-19 January 1918, DDMS Australian Corps – January 1918, AWM: AWM4 26/17/1.

¹² Major Borwick for Brigadier-General, General Staff, Australian Corps 17 January 1918, War Diary Appendix 3, DDMS Australian Corps – January 1918, AWM: AWM4 26/17/1. For ease of reading punctuation in the quote has been corrected.

¹³ Syllabus for Corps School of MOs, No. 2, War Diary Appendix 3, DDMS Australian Corps – January 1918, AWM: AWM4 26/17/1.

¹⁴ Colonel AI Shepherd, War Diary 21 May 1918, ADMS 2nd Aust. Div. – May 1918, AWM: AWM4: 26/19/29 Part 1.

elimination of Main Dressing Stations was discussed. Again we were the only Corps who had already instituted a system of registration on the CCS being reached by the patient.”¹⁵ As was demonstrated in the previous chapter, by the end of Australian participation in the Battle of Passchendaele, the Main Dressing Station, as a medical unit, was well on its way to becoming redundant given that the AAMC had ended all medical recordkeeping other than Field Medical Cards until a casualty reached a CCS and was evacuating casualties directly from Advanced Dressing Stations (ADSs) to CCSs with large numbers of cases skipping the MDS entirely. This principle was taken up and applied by British units outside of the AAMC’s direct influence. In early February the Fifth Army’s Director of Medical Services wrote a memorandum outlining that in “ordinary circumstances” all wounded should be sent directly from the ADS to the CCS and that during “special operations” a walking wounded collecting post should be established to house patients who could soon be returned to duty. Sitting and lying cases were to be evacuated as normal.¹⁶ This suggests that the British Director of Medical Services for the Third Army supported the changes the AAMC had made to casualty clearance and evacuation and was not cognisant of the problems a mobile front would pose to this system developed in the context of virtually immovable front lines.

Preparing for Bombardment: Defensive Medical Planning

Bombardment by the enemy in early March had led the British Army to believe that an attack was imminent from the Germans on the Western Front. The expectation of an attack led to the creation of a new form of medical arrangement by the AAMC. A ‘defence scheme’ was issued by the DDMS for the Australian Corps, Colonel Manifold, on 14 March 1918.¹⁷ It followed much the same principles as had been used in 1917 by the AAMC. The medical plan was communicated to the Australian Corps by Colonel Manifold and provided for three sectors – right, left, and centre – and stated:

Each Division may make its own arrangements for the establishment of Divisional Collecting Stations for sick and Battle Casualties which are so slight that they can be returned almost at once to the line, but no arrangement of this

¹⁵ Colonel CC Manifold, War Diary 18 February 1918, DDMS Australian Corps – February 1918, AWM: AWM4 26/17/2.

¹⁶ DMS Fifth Army, ‘Evacuation from Advanced Dressing Stations’, 7 February 1918, AWM: AWM27 370/249.

¹⁷ Colonel CC Manifold, ‘Medical Arrangements: Issued Under Australian Corps Defence Scheme’, 14 March 1918, War Diary Appendix 3, DDMS Australian Corps – March 1918, AWM: AWM4 26/17/3.

sort must be allowed to hamper the speedy evacuation back from Advanced Dressing Stns of all cases suitable for direct transmission to CCS.¹⁸

Motor Ambulances were provided for evacuation from ADS to CCS and the same recordkeeping practices were maintained with Field Medical Cards “when possible ... made out at ADS, so long as speedy evacuation is not interfered with”, but with the registration of casualties to be undertaken at a Central Bureau at the Casualty Clearing Station.¹⁹ The emphasis of the medical arrangements was on haste, with all but the most minor injuries and illnesses being evacuated directly to the CCS and skipping the MDS all together. It is then reasonable that the medical services had, a month earlier, discussed removing Main Dressing Stations from the medical infrastructure – they no longer served the purpose for which they were originally instituted.

Instead of abolishing Main Dressing Stations (MDSs) the AAMC found other uses for them in the casualty clearance and evacuation process. The defence scheme of medical arrangements laid down by Colonel Manifold in March gave three instances in which casualties should be sent to an MDS. He wrote: “The MDSs will only be used to switch off to if congestion occurs anywhere, for cases of severe shock, and for gassed cases.”²⁰ By allowing them to be used in the case of congestion at other points in the casualty evacuation chain, Colonel Manifold created a flexible casualty evacuation system that was capable of expansion if either, or potentially both, the Advanced Dressing Stations and the Casualty Clearing Stations became overcrowded.

The special provision of using MDSs for cases of gas poisoning were necessary as, although not a new problem, it had become more significant. The use of gas as a weapon became more concerning in the early part of 1918 and it was discussed frequently by the medical men, not just in terms of the immediate effects of exposure but the cumulative effects of the gas lingering in the air. In his War Diary, on 24 March 1918, Colonel Manifold wrote:

Later saw General Walker, G[eneral] O[fficer] C[ommanding] 1st Aust. Dn., and discussed question with him. He was under the impression that the air in

¹⁸ Colonel CC Manifold, ‘Medical Arrangements: Issued Under Australian Corps Defence Scheme’, 14 March 1918, War Diary Appendix 3, DDMS Australian Corps – March 1918, AWM: AWM4 26/17/3.

¹⁹ Colonel CC Manifold, ‘Medical Arrangements: Issued Under Australian Corps Defence Scheme’, 14 March 1918, War Diary Appendix 3, DDMS Australian Corps – March 1918, AWM: AWM4 26/17/3.

²⁰ Colonel CC Manifold, ‘Medical Arrangements: Issued Under Australian Corps Defence Scheme’, 14 March 1918, War Diary Appendix 3, DDMS Australian Corps – March 1918, AWM: AWM4 26/17/3.

forward area had become so impregnated with gas that it had cumulative effect on the men and he said he had felt this himself.²¹

As GOC the 1st Australian Division, General Walker was speaking on the advice of medical officers working in his Division. On 13 March 1918 Captain Keith Stanley Rae, Regimental Medical Officer (RMO) for the 9th Battalion of the AIF, wrote to the battalion's adjutant to request that the unit not be sent forward into the line. He wrote:

In view of the possibility of the Bn going into the line again within a few days, I feel bound to make the following report on their health. All men who showed signs of gas poisoning have been evacuated, but there still remains a large number, who, while not actually ill, are affected in the nose and throat by breathing a low concentration of gas. It would in my opinion be madness to send these men into the line while they are in this condition, as in the event of a gas attack, they would be unable to wear their respirators for any length of time. From the men I have seen on daily sick parades I would say that there would be at least 60 who will not be fit for duty in the line within two weeks. In addition to the men who have been attending sick parades, there are still mild cases developing daily. In my opinion too, the majority of the Bn is more or less affected by the gas, and would find it extremely difficult, if not impossible, to wear gas respirators for a prolonged period.²²

This information about the problem of gas in the 9th Battalion was confirmed by the RMO of the 11th Battalion. The 11th Battalion had relieved the 9th of its place in the line on the night of 8-9 March. On 19 March Major Leonard May, RMO 11th Battalion, wrote to the ADMS 1st Australian Division, Colonel Huxtable, about the problem of gas in the area. He described the gas attack that was sustained by the battalion between 15 and 18 March and the satisfactory "gas discipline" in the unit as demonstrated by there being only one "definitive case" of gassing. He then described in detail the symptoms suffered by the men and compared them to his previous experience of serving in a gas-drenched sector earlier in the war. Major May reported that the lack of sleep due to constant coughing (which, aside from being unpleasant for the individual made him inappropriate for use on a patrol or for duty on an outpost) caused significant problems. He tried to alleviate the problem by "holding four or five in a shelter for two days or so, but [could not] see that they improve

²¹ Colonel CC Manifold, War Diary 24 March 1918, DDMS Australian Corps – March 1918, AWM: AWM4 26/17/3. For ease of reading punctuation in the quote has been corrected.

²² Captain K Rae, RMO 9th Bn, AIF to Adjutant, 9th Bn, AIF, 13 March 1918, War Diary Appendix 32, ADMS 1st Aust. Div. – March 1918, AWM: AWM4 26/18/40.

up here, and the evacuation rates from being very low promises [*sic*] to reach a very high figure”.²³ Major May then recommended that, in a gas-drenched sector, the period of duty in the line should be four, but no more than six, days. In the final sentence of this letter Major May suggested that this problem, if left alone, could affect the efficiency of the army. He wrote: “I think it my duty to lay these facts before you and to state that in my opinion the Bn should not be left until the men are seriously affected and require a very long rest to recover.”²⁴ While the men were not exactly ‘sick’ the Medical Officers intervened and suggested a change to military procedure based on the health effects of remaining in the line. This was not a benevolent request for the good of the soldier; rather, it was a suggestion based on the perception of a looming disaster for the manpower economy of the Australian Imperial Force and ensured there were sufficient men available for military actions.

Planning for the effects of gas was only one of the contingencies worked into the plans for the evacuation of casualties in early 1918. The Assistant Directors of Medical Services (ADMS) for the 1st, 2nd, and 5th Australian Divisions all wrote some form of contingency planning into their schemes for medical arrangements as they prepared to defend the line against a German attack in March 1918. Colonel Huxtable, ADMS 1AD, devised a medical evacuation plan for his division that incorporated alternative routes to be used if the primary routes were inaccessible due to shelling.²⁵ In the 2nd Australian Division the ADMS, Colonel Shepherd, went further in his contingency planning and created plans for medical evacuation in the event of a withdrawal by Australian troops.²⁶ Similar plans were put in place by Colonel Downey, the ADMS for the 5th Australian Division, who drew up plans for relocating Advanced Dressing Stations or Main Dressing Stations if their positions became untenable, as well as providing plans to be enacted if the military situation necessitated the withdrawal of those units.²⁷

²³ Major L May, RMO 11th Bn, AIF to Colonel Huxtable, ADMS 1AD, 19 March 1918, War Diary Appendix 33, ADMS 1st Aust. Div. – March 1918, AWM: AWM4 26/18/40.

²⁴ Major L May, RMO 11th Bn, AIF to Colonel Huxtable, ADMS 1AD, 19 March 1918, War Diary Appendix 33, ADMS 1st Aust. Div. – March 1918, AWM: AWM4 26/18/40.

²⁵ Colonel RB Huxtable, ‘Scheme for Evacuating Wounded from 1st Divisional Front by Trench Tramway’, War Diary Appendix 2, ADMS 1st Aust. Div. – March 1918, AWM: AWM4 26/18/40.

²⁶ Colonel AI Shepherd, ‘Defensive Scheme of Evacuation of Sick and Wounded for Right Divisional Sector of Corps Front’, War Diary Appendix B, ADMS 2nd Aust. Div. – March 1918, AWM: AWM4 26/19/27.

²⁷ Colonel WH Downey, ‘Medical Arrangements in the Event of Major Operations on the Divisional Front’, War Diary Appendix 3, ADMS 5th Aust. Div. – March 1918, AWM: AWM4 26/22/26.

The inclusion at this point of significant contingency planning suggests that those making the medical plans had learned the lessons of previous battles and had a realistic appreciation of the combat units' ability to hold the line against the German advance. Not only were plans put in place for the potential advance or for high casualties for no substantial gain in territory, they were made for a range of other options. In March 1918, in preparation for the impending German attack there were plans for alternative routes of evacuation if stretcher bearers were unable to traverse the original routes, there were plans for the relocation of ADSs and MDSs if they were rendered unsafe due to enemy shelling, and there were plans to shift all units if a complete withdrawal was required because of a German advance. The Australian medical men involved in the development of new casualty evacuation procedures had created, over the course of the war, a flexible system that provided high quality medical care to Australian soldiers involved in combat along a stable front. The problem for the AAMC, and the British medical services more broadly, was that, in 1918, the front line was anything but stationary.

Medicine in Retreat: The German Spring Offensive

On 21 March 1918 the Assistant Director of Medical Services (ADMS) for the 3rd Australian Division received word that the enemy had attacked the British Third and Fifth Armies near Saint-Quentin in Northern France.²⁸ Field Marshal Sir Douglas Haig, Commander-in-Chief, British Armies in France, wrote to all ranks of the British Army in France and Flanders in a 'Special Order of the Day' on 23 March 1918. He wrote:

We are again at a crisis in the War. The enemy has collected on this Front every available Division and is aiming at the destruction of the British Army. We have already inflicted on the enemy in the course of the last two days very heavy loss and the French are sending troops as quickly as possible to our support. I feel that everyone in the Army, fully realizing how much depends on the exertions and steadfastness of each one of us, will do his utmost to prevent the enemy from attaining his object.²⁹

The 3rd and 4th Australian Divisions, including their corresponding medical units, were temporarily attached to the Armies under attack in order to provide further reinforcement to those sections of the line. The 3rd Australian Division was moved into the area on 23

²⁸ Colonel FA Maguire, War Diary 21 March 1918, ADMS 3rd Aust. Div. – March 1918, AWM: AWM4 26/20/18.

²⁹ Field Marshal Sir Douglas Haig, 'Special Order of the Day' 23 March 1918, War Diary Appendix 3, ADMS 3rd Aust. Div. – March 1918, AWM: AWM4 26/20/18.

March and, after an initial mishap with the 9th Australian Field Ambulance (AFA) being left off its train, they were in place, initially in reserve, on 24 March. The Division took up its position in the line on 27 March for the Battle of Dernancourt.³⁰ The 4th Australian Division was in place on 26 March.³¹

The Australian Medical Officers were unimpressed by the handling of the medical arrangements in late March and early April at the Battle of Dernancourt. Colonel Barber, ADMS 4th Australian Division, found the arrangements in the Third Army to be substandard. He wrote: “Medical Arrangements in this Army (Third) seem to be totally disorganized – CCSs have been closed down – some apparently without any justification ... and in consequence all cases have to be evacuated a very long distance to Doullens and its vicinity.”³² In the same entry he also complained of a shortage of stretchers and dressings and a lack of communication and coordination. The problems of waging war in these conditions were also apparent to Colonel Maguire. In his war diary he wrote:

Very little information obtainable as to the situation on Corps Front. Line North of MIRAUMONT reported to be broken and enemy said to be through HEBUTERNE with armoured cars. This was later proved to be wrong.³³

Barber and Maguire criticised the coordination of these Armies when compared to what they had been accustomed to. It is, however, likely that this disorganisation was more an expression of the shift to providing medical care while the combat units were retreating and not yet having adapted to the new circumstances. In early 1918 the ability of the German army to pierce the British lines and move its troops forward highlighted the deficiencies and inconsistencies in the Allies’ communication and casualty evacuation processes.

The British forces, including the Australian Divisions, had become accustomed to evacuating casualties along a static and largely impenetrable front. However, from 1918 the nature of the warfare required a different approach to casualty evacuation and created the need to wind back some of the deviations from medical military doctrine that had been

³⁰ Colonel FA Maguire, War Diary 21 - 28 March 1918, ADMS 3rd Aust. Div. – March 1918, AWM: AWM4 26/20/18.

³¹ Colonel GW Barber, War Diary 26 March 1918, ADMS 4th Aust. Div. – March 1918, AWM: AWM4 26/21/22.

³² Colonel GW Barber, War Diary 26 March 1918, ADMS 4th Aust. Div. – March 1918, AWM: AWM4 26/21/22. For ease of reading punctuation has been corrected.

³³ Colonel FA Maguire, War Diary 26 March 1918, ADMS 3rd Aust. Div. – March 1918, AWM: AWM4 26/20/18.

used in the battles of 1916 and 1917. In early April 1918 Lieutenant General Sir Arthur Sloggett, Director General of Medical Services for the British Armies in France, wrote a memorandum to the Director of Medical Services for the Third Army, to which the 3rd Australian Division was still attached, for distribution to all DDsMS of Corps and all ADsMS of Divisions. In it Sloggett articulated the problems with continuing to use the same system of casualty clearance and evacuation from 1916 and 1917, which had been developed with largely static front lines, in 1918, a situation with vastly more movement. Sloggett wrote:

The experience of the last ten days of March demonstrates the paramount importance of medical units maintaining their mobility in the field. Trench warfare and the desire to carry on surgical work to the highest degree of perfection has led casualty clearing stations to become large and immobile units, pushed as far forward as possible, thus diminishing the tactical importance of maintaining mobile main dressing stations at intermediate positions. The consequence of this has been that in certain areas, Casualty Clearing Stations have had to abandon valuable equipment in retiring, that in some instances no main dressing stations had been opened in their place for the reception of wounded, and that the motor ambulance cars of the field ambulances have been employed in carrying the wounded back to Casualty Clearing Stations to the new positions of the latter further back. In consequence of the time lost in returning from these, the field ambulances cars have not been able to arrive in time to remove lying down cases collected at the collecting post by the bearer divisions, and many wounded unable to walk have been abandoned.³⁴

Sloggett's memorandum suggests that the casualty clearance and evacuation system developed by the Australian Army Medical Corps across 1916 and 1917 was well suited to the type of war being fought at that stage. The efficiency with which injured soldiers reached medical assistance and the quality of the care they received were of a high standard especially during the Battle of Messines. Sloggett, however, advocated a return to previous policies. Pushing the Casualty Clearing Stations further to the rear reinstated the need to have Main Dressing Stations that were mobile and did more than act as overflow capacity for excess patients from Advanced Dressing Stations. He wrote:

³⁴ Lieutenant General Sir AT Sloggett to DMS Third Army, 2 April 1918, War Diary Appendix 5, ADMS 3rd Aust. Div. – April 1918, AWM: AMW4 26/20/19.

Your attention is directed, therefore, to this importance of arranging that when casualty clearing stations are situated far back from the frontline, as they ought to be in the present military situation, intermediate Main Dressing Station position, which can be moved rapidly in echelon backwards or forwards as required shall be established by divisions or Corps, and that the motor ambulance transport of the field ambulances in the front area shall be employed for bringing wounded back only to these Main Dressing Station points.³⁵

These plans by Sloggett reduced the area for which Field Ambulances were to be responsible. The result was that the motor ambulances that worked between Advanced Dressing Stations and Main Dressing Stations had their travel times reduced significantly as Casualty Clearing Stations were removed from their responsibility. This would then enable them to make more trips more frequently, thereby transporting more casualties away from the front to the Main Dressing Station.

In response to the memorandum by Lieutenant-General Sloggett the Australian Divisions began to develop plans to better suit casualty evacuation in mobile warfare. Instead of combining all the bearer divisions of a Division's allotted Field Ambulances under one Commanding Officer, Colonel Barber, who had just replaced Colonel Manifold as DDMS Australian Corps, put forward medical arrangements that began to separate the units again. In his medical instructions issued on 10 April 1918 his policy allowed for one Australian Field Ambulance (AFA) to be in charge of the Advanced Dressing Station, as well as evacuation from RAPs to the Main Dressing Station (MDS). Attached to this AFA, in order to assist with the movement of casualties, was the bearer subdivision of a second AFA whose tent subdivision was in charge of the MDS. Finally the third AFA of an Australian Division was to be held in reserve with one section (roughly a third) of the tent subdivision staffing the Divisional Collection Station for walking wounded. If there was congestion due to large numbers of walking wounded this reserve AFA was to be used to open second collecting station near the MDS to clear casualties more rapidly.³⁶

Not only did the staffing of the various posts in the casualty evacuation chain retreat from the changes made in 1916 and 1917, the use of the Main Dressing Station began to

³⁵ Lieutenant General Sir AT Sloggett to DMS Third Army, 2 April 1918, War Diary Appendix 5, ADMS 3rd Aust. Div. – April 1918, AWM: AMW4 26/20/19.

³⁶ Colonel GW Barber, War Diary Appendix 1, 10 April 1918, DDMS Australian Corps – April 1918, AWM: AMW4 26/17/4.

revert to that of earlier battles and to regain some of its importance. Despite having discussed eliminating MDSs altogether only months before, and then finding alternate uses for the units, they once again became integral parts of the casualty evacuation chain during the German Spring Offensive. This was partly due to the extended distance of the MDS from the Casualty Clearing Station (CCS). Barber ordered: “first aid only to be given at Advance Dressing Station and thorough dressing be undertaken at Main Dressing Stns owing to the distance from Cas. Clg. Stations”.³⁷ An Officer was then detailed to the Main Dressing Station to sort the casualties for their onward movement to a CCS, back to a Divisional or Corps Rest Station or, in the case of “stragglers or malingerers”, to the Military Police.³⁸

During the same month, in the 2nd Australian Division, plans created in case of a retreat involved the ‘leapfrogging’ of medical units. For the fighting around Villers-Bretonneux, the ADMS, Colonel Shepherd, wrote in his ‘Emergency Measures in Necessity of Quick Evacuation’ on 26 April:

Should it be necessary to evacuate an ADS a minimum of personnel and equipment will be left making this only a relay to MDS and a new ADS will be established further back withdrawing the rear party when this new ADS is in working order.³⁹

These plans provided for medical care to be continuously available to Australian soldiers even as the army was forced back.

The on-going issue for the AAMC was the location of Main Dressing Stations and Casualty Clearing Stations, relative to each other and the front line trenches. This was one area where British medical-military authorities questioned the procedures in the Australian Divisions more explicitly. Colonel Downey, Assistant Director of Medical Services for the 5th Australian Division, reported on one such incident in his War Diary. He wrote:

On 29.4.18 the DMS 4th Army inspected MAIN DRESSING STN (14th Aust. Field Ambulance). He believed the station to be too far forward. This question presented itself when the MAIN DRESSING STN was first fixed on. A site at

³⁷ Colonel GW Barber, War Diary Appendix 1, 10 April 1918, DDMS Australian Corps – April 1918, AWM: AMW4 26/17/4.

³⁸ Colonel GW Barber, War Diary Appendix 1, 10 April 1918, DDMS Australian Corps – April 1918, AWM: AMW4 26/17/4.

³⁹ Colonel AI Shepherd, ‘Emergency Measures in Necessity of Quick Evacuation’, War Diary Appendix G, ADMS 2nd Aust. Div. – April 1918, AWM: AWM4 26/19/28.

BUSSY was inspected but rejected, on account of bad roads leading to and from it, this post is however retained for use if necessary. All the horse transport of the 14th Australian Field Ambulance and all spare personnel are in BUSSY or at Ambulance Stn ... so that the equipment of the MAIN DRESSING STN and personnel is all that would have to be removed from DAOURS in case of necessity.⁴⁰

Here Downey demonstrated that although he had realised the MDS was too far forward, there were few other options once the landscape was taken into account. To manage this problem he modified and minimised what was kept at the MDS in order to facilitate a quick retreat if the circumstances of warfare warranted it.

This change back to a casualty evacuation system more reminiscent of the one from early 1916 than one in existence in Australian Divisions in late 1917 was not a result of pressure from the British army to conform to a uniform standard or military doctrine. Sloggett's memorandum provided general principles around which the medical evacuation of casualties should be organised in mobile warfare and the suggestion by the DMS Fourth Army to move the 5th Australian Division's MDS was shown to be a factor already taken into consideration when the MDS was initially set up. These were not instances of overreach by Imperial authorities, rather they were examples of the appropriate oversight of medical care by those who were ultimately responsible for it within the Imperial command. The internal structure at divisional and corps level was still the responsibility of the AAMC Officers who had made the changes that proved so successful at Messines. As they had done in the battles on the Somme and in Flanders, the Australian medical men made decisions about medical care in response to the situation in which they found themselves. This included considering the principles handed down from higher up the command chain, as well as taking into account the landscape, the distance between the Front and the CCS, and the nature of the warfare as it was being waged in the particular battle. Once the AAMC had claimed medical control of Australian casualties, and demonstrated its competence in handling those casualties, its authority over sick and wounded Australian soldiers at divisional and corps level was never seriously challenged by the Royal Army Medical Corps or the British army more generally.

⁴⁰ Colonel WH Downey, 'Work of the Main Dressing Station, Period 21.4.1918 to 30.4.1918', War Diary Appendix 54, ADMS 5th Aust. Div. – April 1918, AWM: AWM4 26/22/27.

In Reserve: May and June on the Western Front

After the Battle of Villers-Bretonneux in late April, the Australian Corps was placed in reserve and whilst there experienced an outbreak of influenza. The May 1918 outbreak, during the lull between major engagements, was an issue of concern among the medical men developing casualty evacuation protocols. Whilst influenza had been a problem before this, a fresh outbreak was problematic when the Allied armies were planning an operation to regain territory claimed by the Germans over the preceding months. Given the need for prompt evacuation of casualties, large numbers of sick not only depleted the effectiveness of the fighting force but also had the potential to create congestion in the evacuation lines and clog up what had become a remarkably smooth process. In the 2nd Australian Division the source of this outbreak was traced to the 28th Battalion. Thirty men in the Battalion slept in one billet with twenty of those presenting themselves for medical checks at the sick parade the following morning; fourteen of them were then evacuated sick. The rest of those thirty men were then isolated from other units and a further eleven were admitted to medical units, meaning that a total of twenty-five were incapacitated. Influenza also affected the efficiency of the AAMC with two Officers and 5 Other Ranks of the 5th Australian Field Ambulance, who provided care to the 28th Battalion's sick, also needing to be evacuated to the CCS for care and recovery.⁴¹

Colonel Shepherd, ADMS for the 2nd Australian Division, pointed out that “exactly the same condition of Pyrexia was prevalent among the troops of this Division at the same time last year, which points to a vernal infection to which these men are predisposed”.⁴² He suggested that it was easier for the infection to spread when units were behind the lines in billets rather than in trenches where the men tended to be more spread out. Colonel Shepherd reported that slight or suspicious cases were held in the Field Ambulances' medical posts, which goes some way to explaining the high rate of infection among the division's Field Ambulance personnel. Given that the disease first presented as fever, which could indicate multiple illnesses, the soldiers were initially diagnosed with Pyrexia of Unknown Origin (PUO). On 11 May, Colonel Shepherd gave the sick admissions rates for the eight previous days to Colonel Barber, the DDMS of the Australian Corps, stating that

⁴¹ Colonel AI Shepherd, 'Report concerning high incidence of sickness in battalions during the past fortnight', 11 May 1918, War Diary Appendix E, ADMS 2nd Aust. Div. – May 1918, AWM: AWM4: 26/19/29 Part 1.

⁴² Colonel AI Shepherd, 'Report concerning high incidence of sickness in battalions during the past fortnight', 11 May 1918, War Diary Appendix E, ADMS 2nd Aust. Div. – May 1918, AWM: AWM4: 26/19/29 Part 1.

admissions due to PUO were 291 of 443 (or 66 per cent) of total admissions due to sickness, and evacuations due to PUO were 203 of 282, or 72 per cent of total evacuations due to sickness from the 2nd Australian Division.⁴³

Influenza and the attempts to limit its effects was discussed by medical officers. On 21 June 1918, Colonel Huxtable, ADMS of the First Australian Division forwarded information from the DDMS of the British XV Corps to the Regimental Medical Officers under his care. This information suggested that the “influenza-like disease” they were working against appeared to be air-borne and warned against overcrowding in billets and impressed upon RMOs the importance of ventilation.⁴⁴ Preventative measures were also put in place in the First Australian Division that replicated those put forward by the DDMS of the British XV Corps. He suggested that for several days after exposure to infection soldiers should use a system of nasal douching and gargling with antiseptic solutions daily, and if possible twice a day. This system, recommended by the DDMS, cited a recent issue of the *British Medical Journal* from March 1918 on the prevention of epidemic disease in schools.⁴⁵ A few days after these instructions were given regarding influenza, the Director General of Medical Services (DGMS) for the British Armies in France gave further instructions. He repeated the calls to minimise overcrowding of men in tents, billets, and mess rooms, and wrote: “Whenever the military situation permits, it is advisable that troops should sleep in individual blanket-shelters in the open air.”⁴⁶ Other precautions suggested included airing all blankets and kits from the billets where infections had occurred and quarantining new arrivals to the area. The DGMS wrote:

As the infection appears to be spread by the movement of infected individuals, drafts arriving at Reinforcement Depots from England or the Bases should, as far as possible, be accommodated in separate lines for a period of 4 days.

⁴³ Colonel AI Shepherd, ‘Report concerning high incidence of sickness in battalions during the past fortnight’, 11 May 1918, War Diary Appendix E, ADMS 2nd Aust. Div. – May 1918, AWM: AWM4: 26/19/29 Part 1.

⁴⁴ Colonel RR Huxtable, ‘Influenza’, 21 June 1918, War Diary Appendix 11, ADMS 1st Aust. Div. – June 1918, AWM: AWM4 26/18/43 Part 1.

⁴⁵ Colonel RR Huxtable, ‘Influenza’, 21 June 1918, War Diary Appendix 11, ADMS 1st Aust. Div. – June 1918, AWM: AWM4 26/18/43 Part 1.

⁴⁶ Major General JH Thomson for DGMS British Armies in France, 25 June 1918, War Diary Appendix 15, ADMS 1st Aust. Div. – June 1918, AWM: AWM4 26/18/43 Part 1.

Individual shelters should be insisted on in order to avoid the necessity for quarantine if any cases arise.⁴⁷

This information was passed along to all RMOs and Commanding Officers of Field Ambulances in the Fifth Australian Division by the ADMS, Colonel Downey.⁴⁸ This sharing of information highlights the change in priorities in the medical services between major combat operations. Unsurprisingly, during major offensives the focus of the medical men was on casualty evacuation and treatment yet when the fighting subsided the medical services' attentions were drawn to preventative health measures in order to maintain the fighting strength of the army. As a result, the AAMC exerted influence over the AIF soldiers' bodies outside of battle.

Along with the outbreak of influenza, the quiet period between major offensives on the Western Front in May and June 1918 was also a time of administrative change in the British Medical Services. One key difference between the Commander-in-Chief of the Mediterranean Expeditionary Force (MEF), Sir Ian Hamilton, and the Commander-in-Chief of British Armies in France, Sir Douglas Haig, was the extent to which they engaged with their respective medical services. At Gallipoli, as was demonstrated in Chapter 1, Hamilton excluded the medical services from preparations for battle. In contrast, Haig's approach demonstrated an awareness of the significance of the medical services. Military historian Gary Sheffield suggested that Haig had learned the lessons of Gallipoli and the early days of the war in France, writing: "Typically, Haig took a close interest in medical matters and proved very supportive of his senior medical staff as they carried out radical changes in response to the lessons learned in the first years of the war."⁴⁹ Haig recognised the problem of Sir Arthur Sloggett, DGMS in France and Flanders, being forced to retire in the middle of a war during what had become the fighting season. On 19 May 1918 Haig noted in his diary that Sloggett was being made to retire at 60 and wrote of his intent to ask the War Office to reconsider its decision.⁵⁰ By 22 May he had received word from the War Office that Lieutenant Colonel CH Burtchaell was to replace Sloggett. If Sloggett had to be replaced, Burtchaell was not Haig's preferred candidate. In response to this Haig had

⁴⁷ Major General JH Thomson for DGMS British Armies in France, 25 June 1918, War Diary Appendix 15, ADMS 1st Aust. Div. – June 1918, AWM: AWM4 26/18/43 Part 1.

⁴⁸ Colonel WH Downey, 'ADMS Circular No. 9', War Diary Appendix 22, ADMS 5th Aust. Div. – June 1918, AWM: AWM4 26/22/29.

⁴⁹ Sheffield, *The Chief*, 143.

⁵⁰ Sir Douglas Haig, 19 May 1918, Haig's Diary with supps vol. XXIX – May 1918, National Library of Scotland (hereafter NLS): Acc.3155/127.

written to the Secretary of State for War, Lord Milner, and considered it a certainty that Sloggett would remain in his post as a result of his intervention.⁵¹

Haig was wrong and Sloggett was compelled to retire on 1 June 1918, due to the British Army's age restrictions. When documenting in his diary a lunch he had with Sir Anthony Bowlby, Consulting Surgeon to the BEF, Haig wrote:

Sloggett's great merit is that he has allowed the Civil Surgeons and Medical men to do what they thought necessary without any interference. I told Bowlby that I had written to Milner (S. of S. for War) but he declined to modify the War Office decision because it would be unfair to rising men in the Army Medical Corps to keep Sloggett and others on, after the age limit. I added that I would do my best to see that no interference by the new DGMS took place; and B. is to come and report from time to time on what is being done.⁵²

Haig's statement that Sloggett minimised his interference with the civilians in the medical corps is borne out by his previously discussed direction to the Medical Officers to observe certain principles in the planning of medical evacuation in mobile warfare. As has been outlined by historian Ana Carden-Coyne, Sloggett was an advocate for the use of civilian doctors in the military during the war whereas Burtchaell was uncomfortable with this deployment of resources.⁵³ Haig, appearing to value the independence afforded civilian surgeons and medical men, undertook to see that it continued and, assuming that the 'B.' in the above quote refers to Bowlby and not Burtchaell, he intended to use Bowlby as an informant to ensure Burtchaell did not interfere unnecessarily.

This was the context in which the Australian Army Medical Corps worked for the remainder of the war. A situation in which civilian medical expertise had come to be valued by one of the highest ranked military officers. Mark Harrison's assessment of the remaining months of the war support this idea. He argued that "the last few months of fighting on the Western Front provide ample evidence that the medical services had been fully integrated into operational planning and that the evacuation and treatment of casualties was a matter of high priority."⁵⁴ This acceptance of civilian medical expertise in the Royal Army

⁵¹ Sir Douglas Haig, 22 May 1918, Haig's Diary with supps vol. XXIX – May 1918, NLS: Acc.3155/127.

⁵² Sir Douglas Haig, 24 May 1918, Haig's Diary with supps vol. XXIX – May 1918, NLS: Acc.3155/127.

⁵³ Carden-Coyne, *The Politics of Wounds*, 92.

⁵⁴ Harrison, *The Medical War*, 91.

Medical Corps flowed through to the Australian Army Medical Corps and the work at divisional and corps level of the AAMC is remarkable for the absence of interference from the British services.

The Battle of Hamel and the Hundred Days Offensive: Medicine on the Advance

A conference of medical men in charge of the Australian Corps and 2nd and 4th Australian Divisions was held on 1 July 1918 to finalise medical arrangements for the Battle of Hamel. The battle commenced on 4 July under the command of the General Officer Commanding the 4th Australian Division and therefore the evacuation of casualties was the responsibility of the Assistant Director of Medical Services of that Division, Lieutenant Colonel Roy Stanley McGregor, who was temporarily acting in that role. His responsibilities included the casualties on the 2nd Divisional Front so the Acting ADMS of the 2nd Australian Division, Lieutenant Colonel William Crowther, reported to the ADMS 4th Australian Division for the duration of the Battle. Action commenced at 3:10am and Crowther described the evacuation from his area as “remarkabl[y] prompt and successful”.⁵⁵ Crowther reported that the shelling of back areas was light and as a result the Motor Ambulances were able to push almost the whole way forward to the Regimental Aid Posts in order to evacuate casualties back to the ADS. By 10:00am almost all casualties had been evacuated at least to the ADS and in this the stretcher bearers were assisted, as had become commonplace, by captured German Prisoners of War who were pushed into service in casualty clearance.⁵⁶ Lieutenant Colonel McGregor reported that in the twelve hours after zero hour (3:10am) more than 800 cases had been evacuated, which equated to more than one per minute over a distance of 7000 yards with an abnormally high ratio of lying to walking cases (3:4).⁵⁷

The Allied counterattack to the German Spring Offensive, the Hundred Days Offensive, commenced with the Battle of Amiens on 8 August in which the Australian Corps participated. The Corps was also involved in the subsequent advance to the Hindenburg Line including fighting at the Battle of Mont Saint-Quentin (including

⁵⁵ Lieutenant Colonel WELH Crowther, War Diary 4 July 1918, ADMS 2nd Aust. Div. – July 1918, AWM: AWM4 26/19/31 Part 1.

⁵⁶ Lieutenant Colonel WELH Crowther, War Diary 4 July 1918, ADMS 2nd Aust. Div. – July 1918, AWM: AWM4 26/19/31 Part 1.

⁵⁷ Lieutenant Colonel RS McGregor, ‘AAMC Narrative of Operation of 4th July 1918’, 7 July 1918, War Diary Appendix 11A, ADMS 4th Aust. Div. – July 1918, AWM: AWM4 26/21/26.

Péronne) from 31 August to 3 September and the attempts to capture the Hindenburg Line from 18 September with the line breaking on 29 September. After the capture of Montbrehain on 5 October the Australian Corps was withdrawn from active duty for retraining and reorganisation after six months in the line and the Armistice was signed before they returned to active service. The casualty clearance and evacuation systems that had been developed in stationary warfare over the preceding years and tested and refined with a retreating mobile front earlier in 1918 continued to work well when the force was on the advance.

The morning of 8 August 1918 was described by Colonel Shepherd, ADMS 2nd Australian Division, as a “Fine morning with a ground mist, most favourable for attack.”⁵⁸ From Colonel Shepherd’s perspective the events of the day could not have been much better. He reported that the attack appeared to be “a complete surprise to the Germans” and he also wrote that “The whole of the Medical Arrangements seem to have gone without a hitch.”⁵⁹ This success was due, in part, to good planning and the clarification of command issues prior to the commencement of the attack. A conference was held on 3 August for the ADsMS of the Australian Divisions with the DDMS Australian Corps to discuss the medical arrangements for the impending operations. The following day Colonel Shepherd held a conference with the Commanding Officers of the AFAs under his command as well as the ADMS of the neighbouring 5th Australian Division, Colonel Downey. Colonel Shepherd recorded in his war diary: “The whole of the Medical Arrangements of intended Operations was discussed ... and the cooperation of all Medical Units of both Divisions was arranged.”⁶⁰ The area to the right of the Australian Divisions was under the control of the 2nd Canadian Division and Colonel Shepherd also made arrangements with the ADMS of that Division to assist each other if either Division encountered any problem with its medical arrangements.

While it was decided that the Field Ambulances of both the 2nd and 5th Australian Divisions would work in cooperation at each medical station throughout the action there

⁵⁸ Colonel AI Shepherd, War Diary 8 August 1918, ADMS 2nd Aust. Div. – August 1918, AWM: AWM4 26/19/32 Part 1.

⁵⁹ Colonel AI Shepherd, War Diary 8 August 1918, ADMS 2nd Aust. Div. – August 1918, AWM: AWM4 26/19/32 Part 1.

⁶⁰ Colonel AI Shepherd, War Diary 9 August 1918, ADMS 2nd Aust. Div. – August 1918, AWM: AWM4 26/19/32 Part 1.

was still some confusion as to command.⁶¹ Colonel Shepherd received a report from Lieutenant Colonel Welch, Commanding Officer of the 6th Australian Field Ambulance and Officer Commanding the MDS for the Divisional Sector for the Battle of Amiens, that the plans Welch had made for the battle were in conflict with orders given by Colonel Downey, the ADMS of the 5th Australian Division. Downey had wired the Commanding Officer of the 14th Australian Field Ambulance to say that he should take over command of the MDS from Lieutenant Colonel Welch at Zero hour (4:20am) plus 44 minutes. In response to the report from Welch, Colonel Shepherd wrote that he:

Phoned Colonel DOWNEY and explained that it was not a fair arrangement as Lt.Col. WELCH had made all preparations for the battle at MDS and it was unfair to change the command until MDS moved from there. Finally arranged that Lt Col. WELCH retains command. Saw all Ambulance Commanders and went over the instructions so that there should be no misunderstanding.⁶²

The close working relationship of between the two ADsMS of the 2nd and 5th Australian Divisions enabled this issue to be resolved before the battle commenced.

In much the same way as the 2nd and 5th Australian Divisions worked together during the battle the 3rd and 4th Australian Divisions were also paired. At Zero plus 4 hours the command in this Divisional Sector passed to the General Officer Commanding (GOC) the 4th Australian Division at which point the personnel of both the 3rd and 4th Australian Divisions came under his control.⁶³ The GOC 4AD held a conference on 1 August at which he outlined his plan of operations. In his report on the medical arrangements for the battle, Colonel Kenneth Smith, ADMS 4th Australian Division, wrote that two possible outcomes were “immediately evident”. Either the operations would be successful and “the casualties would be light and provision would have to [be] made for the rapid advance of Dressing Stations in order to ease the strain on Divisional Ambulance Transport”, or else if the Divisions were not successful “casualties would be heavy and all the resources of both the 3rd and 4th Australian Divisions would be needed for the efficient evacuation and

⁶¹ Colonel AI Shepherd, War Diary 6 August 1918, ADMS 2nd Aust. Div. – August 1918, AWM: AWM4 26/19/32 Part 1.

⁶² Colonel AI Shepherd, War Diary 7 August 1918, ADMS 2nd Aust. Div. – August 1918, AWM: AWM4 26/19/32 Part 1. For ease of reading the punctuation has been corrected in the quote.

⁶³ Colonel K Smith, ‘Medical Arrangements No. 1’ 5 August 1918, War Diary Appendix 9, ADMS 4th Aust. Div. – August 1918, AWM: AWM4 26/21/27.

treatment of the casualties”.⁶⁴ According to Colonel Smith “The obvious solution was, therefore, to pool the Medical Units of both Divisions and place the Ambulances so that both alternatives could be met with equal success.”⁶⁵ The result of the evacuation in this Divisional Sector was similar to that of the 2nd and 5th Australian Divisions with Colonel Smith reporting that “all arrangements worked splendidly”.⁶⁶

As can be seen by the averted problem in the 2nd and 5th Australian Divisional Sector, as discussed above, the changing command of Main Dressing Stations, as necessitated by the change to a more mobile form of warfare, had become a source of confusion for the ADsMS for the five Australian Divisions. On 12 August, after the Battle of Amiens, Colonel Barber, DDMS Australian Corps, wrote to his ADsMS to clarify the procedures for forming, opening and closing MDSs. He reinforced the authority of the ADsMS to decide when and where to position and move Main and Advanced Dressing Stations but reminded the Officers that he and the Officer Commanding the Motor Ambulance Convoy needed to be informed as early as possible of the intent to make changes so as to prevent congestion and maintain the satisfactory clearance from those posts. Barber also wrote that each Divisional sector was to have only one MDS, which were limited in number because of a shortage of Motor Ambulances to appropriately clear the casualties on to a CCS. Given the success of the attack on 8 August where Divisions worked in tandem, Barber also used the opportunity to outline the procedure for the deployment of medical personnel in the event of an advance where one Division leapfrogged another. Barber wrote:

In the event of a Division passing through another Division (leapfrogging, as in recent operations) to attack a position beyond, tent division personnel of the attacking Division must double up at Main Dressing Station, Advanced Dressing Station, and all posts of the Division through which the attack Division passes.⁶⁷

⁶⁴ Colonel K Smith, ‘Medical Arrangements 8th – 10th August 1918’, 28 August 1918, War Diary Appendix 20, ADMS 4th Aust. Div. – August 1918, AWM: AWM4 26/21/27.

⁶⁵ Colonel K Smith, ‘Medical Arrangements 8th – 10th August 1918’, 28 August 1918, War Diary Appendix 20, ADMS 4th Aust. Div. – August 1918, AWM: AWM4 26/21/27.

⁶⁶ Colonel K Smith, ‘Medical Arrangements 8th – 10th August 1918’, 28 August 1918, War Diary Appendix 20, ADMS 4th Aust. Div. – August 1918, AWM: AWM4 26/21/27.

⁶⁷ Colonel GW Barber, DDMS Australian Corps to ADsMS of Australian Divisions, 12 August 1918, War Diary Appendix 4, DDMS Australian Corps – August 1918, AWM: AMW4 26/17/8.

Once the front line had been pushed far enough forward and the area secured then the advancing medical units could, for example, turn the Advanced Dressing Station into an MDS, a Regimental Aid Post into an ADS and establish forward RAPs, in the way suggested by Colonel Anderson at Messines.⁶⁸ Colonel Downey showed he was aware of the issue of consolidating the territorial gains before sending forward further medical units at the Battle of Amiens where he reported:

I did not form an ADS and W[alking] W[ounded] D[ressing] S[tation] immediately after capture of RED LINE (though Motor Posts were established) because I consider it tactfully unsound to send forward Tent Division personnel into captured territory before the objective is definitely consolidated.⁶⁹

Colonel Barber also provided a procedure for closing MDSs so that his instruction that only one be open in each Divisional sector at any time was able to be followed. He wrote:

When a Main Dressing Station opens in a Sector, the station previously acting as Main Dressing Station for that sector must automatically close at the same hour, and become a Reserve Dressing Station. The M[otor] A[mbulance] C[onvoy] will clear remaining patients, and afterwards should it be necessary to send patients to Reserve Dressing Station owing to congestion at Main Dressing Stations on application by C[ommanding] O[fficer] or ADMS to O[fficer] C[ommanding] Motor Ambulance Convoy.⁷⁰

The Reserve Dressing Station (RDS) was then to be used either in the case of congestion at the MDS or in the event that the advance was rebuffed and the attacking Division had to retreat. For this reason Barber ordered that either a tent subdivision of a Field Ambulance or 'holding parties' – made up of either Divisional Collecting Station or dental unit personnel – should staff the RDS. Through this personnel deployment the RDS was staffed with medically trained men but those with the most experience treating and evacuating wounded were pushed forward. This clarification of the use of MDSs by Colonel Barber provided for a casualty evacuation chain that could push forward or back as required and was the type of scheme that Colonel Smith had reported was necessary for the Battle of Amiens. The scheme outlined the administrative procedures for the ADsMS

⁶⁸ See Chapter 2, page 67.

⁶⁹ Colonel WH Downey, ADMS 5AD to DDMS Australian Corps, 9 August 1918, War Diary Appendix 44, DDMS Australian Corps – August 1918, AWM: AWM4 26/17/8.

⁷⁰ Colonel GW Barber, DDMS Australian Corps to ADsMS of Australian Divisions, 12 August 1918, War Diary Appendix 4, DDMS Australian Corps – August 1918, AWM: AMW4 26/17/8.

to follow in establishing, relocating, and closing MDSs but ensured that the authority to select the timing and location of those changes rested with the ADMS of a Division.

The Battles of Mont Saint-Quentin and Péronne from 27 August to 4 September involved frequent moves forward by medical posts. Colonel Shepherd, in his report on the operations during the period in question, wrote: “it might be borne in mind that for several days forward posts were constantly on the move and changed from hour to hour”.⁷¹ The success of the arrangements was due to three main reasons. First, Ford Cars were used as far forward as possible to evacuate casualties. Second, one tent subdivision of a Field Ambulance was held in reserve so that it could move forward when needed to establish a new Advanced Dressing Station. Once the advance of other units was complete the rear tent subdivision became the reserve unit, which would advance when next needed. Finally, the use of telephones between the Advanced Dressing Station and the associated infantry brigade enhanced communication and coordination between medical and fighting units.⁷² Colonel Shepherd reported that the “system in practice was found to work admirably”.⁷³

During the German Spring Offensive, between March and May 1918, it became necessary to unwind some of the changes to the use of Australian Field Ambulances that had been made during stationary warfare. Subsequently, the mobility of the front during the fighting in late August and early September, during the Hundred Days Offensive, necessitated further changes back to a more traditional structure of the Field Ambulances. Colonel Shepherd wrote that, “for such mobile operations” it was important to attach the Ambulance Bearer Divisions to their respective infantry Brigades.⁷⁴ The need for this change was echoed by Colonel Downey, ADMS 5AD, in his report on the action.⁷⁵ This was not a complete reversion to the original scheme used in early 1916 as the bearer and tent subdivisions of an Australian Field Ambulance were not linked. The tent subdivisions

⁷¹ Colonel AI Shepherd, Memorandum to Divisional Headquarters, 5 September 1918, War Diary Appendix Z3, ADMS 2nd Aust. Div. – August 1918, AWM: AWM4 26/19/32 Part 2.

⁷² Colonel AI Shepherd, Memorandum to Divisional Headquarters, 5 September 1918, War Diary Appendix Z3, ADMS 2nd Aust. Div. – August 1918, AWM: AWM4 26/19/32 Part 2.

⁷³ Colonel AI Shepherd, Memorandum to Divisional Headquarters, 5 September 1918, War Diary Appendix Z3, ADMS 2nd Aust. Div. – August 1918, AWM: AWM4 26/19/32 Part 2.

⁷⁴ Colonel AI Shepherd, Memorandum to Divisional Headquarters, 5 September 1918, War Diary Appendix Z3, ADMS 2nd Aust. Div. – August 1918, AWM: AWM4 26/19/32 Part 2.

⁷⁵ Colonel WH Downey, ‘Report on Medical Arrangements for Operation on 27, 28, 29 and 30 August 1918’, 2 September 1918, War Diary Appendix 37, ADMS 5th Aust. Div. – August 1918, AWM: AWM4 26/22/31 Part 2.

were used to staff various posts with one in reserve, as discussed above, and the bearer subdivision moved with its infantry brigade to evacuate casualties.

The medical arrangements for subsequent actions involving the Australian Corps in September and early October worked similarly to those in August. Colonel Barber, DDMS Australian Corps, recorded in his war diary on the days of the main offensives (18, 29/30 September and 5 October) that the casualty evacuation was smooth and the medical arrangements worked satisfactorily.⁷⁶ The Australian Corps was withdrawn from the line in the days following its final action on 5 October and it did not return to active service in the First World War. The evacuation of casualties from the Australian Divisional Sectors was undertaken throughout the Hundred Days Offensive with minimal involvement from the Imperial authorities. The processes were managed and refined by the Officers of the Australian Army Medical Corps who were given the authority to make decisions as was appropriate to their rank and role in much the same way that Officers in the Royal Army Medical Corps made decisions within their Divisions.

Operating in Forward Areas: The Development of Resuscitation Teams

In the midst of these changes to the structures and processes that shaped the provision of medical care to Australian soldiers, the AAMC continued to refine medical treatments provided in the forward medical posts. While the focus remained on the efficient and prompt evacuation of casualties away from the front, members of the AAMC advocated for an ‘operating centre’ close to the front. On 18 May 1918 Colonel Downey, ADMS 5th Australian Division, wrote to the DDMS of the Australian Corps, Colonel Barber, to suggest the establishment of an “Advanced (or Divisional) Operating Centre”.⁷⁷ The medical arrangements at the time required casualties to be evacuated a distance of 16 miles and Downey was of the opinion that “A proportion of these cases would ... materially benefit by early operation in the Divisional Area.”⁷⁸ He based this recommendation on a similar plan that had been put in place during military operations before Bapaume in April 1917, and he also noted that there was provision for this in the Field Service Regulations

⁷⁶ Colonel GW Barber, War Diary 18, 29-30 September 1918, DDMS Australian Corps – September 1918, AWM: AMW4 26/17/9; Colonel GW Barber, War Diary 4-6 October 1918, DDMS Australian Corps – October 1918, AWM: AMW4 26/17/10.

⁷⁷ Colonel WH Downey, ADMS 5AD to DDMS Australian Corps, 18 May 1918, War Diary Appendix 15, ADMS 5th Aust. Div. – May 1918, AWM: AWM4 26/22/28.

⁷⁸ Colonel WH Downey, ADMS 5AD to DDMS Australian Corps, 18 May 1918, War Diary Appendix 15, ADMS 5th Aust. Div. – May 1918, AWM: AWM4 26/22/28.

and RAMC Training. The recommendation was also based on the experience of the 14th Australian Field Ambulance's (14AFA) work in May 1918. In the period 5-19 May 1918 that unit ran the 5th Australian Division's Main Dressing Station and a report written by the Officer Commanding 14AFA, Lieutenant Colonel Thompson, outlined the operations performed at the MDS by a specialist team. In his report Thompson demonstrated why these operating centres were considered necessary. He wrote:

I believe that on the average for every 1000 wounded evacuated there are not more than 20 cases which cannot be sent to the CCS, but in these 20 cases the long trip to CCS is almost always fatal, whereas an Advanced Operating Centre would save the lives of the majority of these.⁷⁹

Here Thompson highlighted one of the fundamental problems in military medicine in the First World War. The scale of the casualties was such that efficient systems that provided the majority of cases with positive outcomes were needed, and the system that had been developed, of minimal intervention in forward areas combined with rapid evacuation of casualties to well-equipped and staffed hospitals, fulfilled this need. Yet that system did not provide much more than palliative care for those whose wounds required immediate intervention. Thompson provided case notes for all 17 operations conducted in the period recording only one fatality with the rest moved to the CCS in good condition. He reported:

The experience gained at DAOURS indicates to me that there should be attached to each division, and placed at the disposal of the ADMS, an operative team; this team should be placed at a distance of about 10 miles from the front line, and either attached to the Ambulance situated furthest back or placed in an isolated building or tentage in a location unlikely to be shelled.⁸⁰

As the ADMS for the Division, Downey was impressed by the work of the team operating at his MDS and wrote to Barber:

I suggest therefore that under present conditions and during spring and summer when severe cases could, after operation, be sent immediately to CCS, that a surgeon be sent from a CCS to establish an Operating Centre at the Divisional Collecting Station. In the case of this Division the CCS is situated in a very good house at Les Alencons, containing electric light, and other

⁷⁹ Lieutenant Colonel CW Thompson, CO 14AFA, 'Report on Operative Work Performed at the 5th Australian Divisional Main Dressing Station in DAOURS for Period 5th May 1918 to 19th May 1918', 30 May 1918, War Diary Appendix 15, ADMS 5th Aust. Div. – May 1918, AWM: AWM4 26/22/28.

⁸⁰ Lieutenant Colonel CW Thompson, CO 14AFA, 'Report on Operative Work Performed at the 5th Australian Divisional Main Dressing Station in DAOURS for Period 5th May 1918 to 19th May 1918', 30 May 1918, War Diary Appendix 15, ADMS 5th Aust. Div. – May 1918, AWM: AWM4 26/22/28.

conveniences. It happens also that the CO is an officer of considerable surgical experience, and at least one member of the unit is an Operating Theatre attendant of experience.⁸¹

Underlining his point that this suggestion was not intended to undermine or detract from the arrangements already existing, Downey concluded by writing: "It is not suggested that the principle of 'only urgent operations at a Field Ambulance' be departed from, except under the expert judgment of the surgeon in charge."⁸²

Colonel Barber forwarded the letter from Downey to Major General O'Keefe, the British Director of Medical Services for the Fourth Army. Barber recommended to O'Keefe that Downey's proposal be adopted and that advance operating centres should be placed as far forward as possible. Barber wrote:

If a patient is likely to die as the result of a long journey to CCS it would be better for him to remain close to the line and risk shell fire. Such cases are few in number and the accomodation [*sic*] should, I think, be limited to that for 30 cases.⁸³

In Downey's opinion a potentially life-saving operation conducted under the threat of shell fire but with the possibility of survival was preferable to a likely fatal journey to treatment.

The response Barber received from O'Keefe was lukewarm. O'Keefe replied: "The principle of an Advanced Operating Centre is in some respects desirable, but the exigencies of the present warfare do not allow of it."⁸⁴ O'Keefe then suggested that the time to carry a wounded soldier to the CCS would be under an hour. He showed enough interest in the proposed scheme to discuss it with Sir Anthony Bowlby, Consulting Surgeon to the BEF, but Bowlby was also sceptical of it. O'Keefe wrote to Barber:

I have spoken to Sir Anthony Bowlby and other Consulting Surgeons on this matter, and they are all of the opinion that an extra hour on the road is more than compensated for by the advantage of getting a patient to a well

⁸¹ Colonel WH Downey, ADMS 5AD to Colonel GW Barber, DDMS Australian Corps, 18 May 1918, War Diary Appendix 15, ADMS 5th Aust. Div. – May 1918, AWM: AWM4 26/22/28.

⁸² Colonel WH Downey, ADMS 5AD to Colonel GW Barber, DDMS Australian Corps, 18 May 1918, War Diary Appendix 15, ADMS 5th Aust. Div. – May 1918, AWM: AWM4 26/22/28.

⁸³ Colonel GW Barber, DDMS Australian Corps to Major General WW O'Keefe, DMS Fourth Army, 21 May 1918, War Diary Appendix 15, ADMS 5th Aust. Div. – May 1918, AWM: AWM4 26/22/28.

⁸⁴ Major General WW O'Keefe, DMS Fourth Army, to Colonel GW Barber, DDMS Australian Corps, 24 May 1918, War Diary Appendix 15, ADMS 5th Aust. Div. – May 1918, AWM: AWM4 26/22/28.

established hospital, where he can rest for ten or fifteen days after a severe chest of abdominal operation, and escape the risk of shell gas and gun fire.⁸⁵

O’Keefe and Bowlby therefore disagreed with the Australian Medical Officers on this point. O’Keefe finished his communication with Barber by criticising the location of the medical units for the 5th Australian Division writing: “I would remind you that at my recent inspection I pointed out that your MDS at DAOURS would more suitably be located at ‘LES ALLENCONS’; the trouble in this case is that your MDS is too far forward.”⁸⁶

The criticisms of the plan from the members of the RAMC did not deter the AAMC Medical Officers from making changes, albeit slightly modified from those originally advocated. Colonel Barber forwarded O’Keefe’s response to Colonel Downey, ADMS 5th Australian Division, writing: “It will therefore be necessary to provide, when possible accomodation [*sic*] at MDS for cases which are not likely to survive the journey. This could be done at ‘LES ALLENCONS’.”⁸⁷ Colonel Downey, in turn, forwarded O’Keefe’s reply along with a memorandum outlining the arrangements to the Headquarters of his Division for the attention of the Commanding Officer. Downey reported that arrangements had already been made for urgent operations to be undertaken at the Divisional Collecting Station at Les Alencons and demonstrated to the CO that this was in line with regulations stating: “This will be in accordance with Field Service Regulations, and the Station will not be an ‘Advanced Operating Centre’ in the strict interpretation of the term.”⁸⁸ This was a semantic distinction rather than an accession to the criticisms of O’Keefe and Bowlby. In response to O’Keefe’s criticisms of the location of the 5th Australian Division’s MDS Downey reassured the Divisional CO that the site had been approved by the DDMS of the Australian Corps, was 11,500 yards from the front line, enabled the prompt reinforcement of stretcher bearers, and had been moved 2000 yards backwards, further behind the lines, since the DMS of the Fourth Army had visited, and it was therefore not where he had thought.⁸⁹

⁸⁵ Major General WW O’Keefe, DMS Fourth Army, to Colonel GW Barber, DDMS Australian Corps, 24 May 1918, War Diary Appendix 15, ADMS 5th Aust. Div. – May 1918, AWM: AWM4 26/22/28.

⁸⁶ Major General WW O’Keefe, DMS Fourth Army, to Colonel GW Barber, DDMS Australian Corps, 24 May 1918, War Diary Appendix 15, ADMS 5th Aust. Div. – May 1918, AWM: AWM4 26/22/28.

⁸⁷ Colonel GW Barber, DDMS Australian Corps, to Colonel WH Downey, ADMS 5AD, 25 May 1918, War Diary Appendix 15, ADMS 5th Aust. Div. – May 1918, AWM: AWM4 26/22/28.

⁸⁸ Colonel WH Downey, ADMS 5AD to Headquarters, 5AD, 27 May 1918, War Diary Appendix 15, ADMS 5th Aust. Div. – May 1918, AWM: AWM4 26/22/28.

⁸⁹ Colonel WH Downey, ADMS 5AD to Headquarters, 5AD, 27 May 1918, War Diary Appendix 15, ADMS 5th Aust. Div. – May 1918, AWM: AWM4 26/22/28.

When the Australian Corps returned to the line for the Battle of Hamel in early July 1918 surgical work was undertaken at the 4th Australian Division's MDS. In his report on the work of the AAMC during the Battle, Lieutenant Colonel McGregor, Acting ADMS for the Division wrote: "Special mention must be made of the most excellent work at MDS by Major A. Holmes à Court in doing a) urgent surgical operations, b) blood transfusions."⁹⁰ Major Alan Worsley Holmes à Court had worked in both private practice in Sydney and as Assistant Physician at Sydney Hospital prior to the war. He enlisted in the AIF in March 1915 and worked on board the *Karoola* as Medical Officer and was posted to the 2nd Australian General Hospital, stationed in France, before he was promoted to Major and moved to the 4th Australian Field Ambulance.⁹¹ Of Holmes à Court's work at Hamel, McGregor reported:

The surgical operations were done to arrest haemorrhage and to remove badly shattered limbs, The Blood transfusion was done to counteract shock. After this treatment cases were put in a special resuscitation room and after they had reacted (2-4 hours) were sent on to CCS. Seven cases were transfused and on enquiry at CCS we were informed that 6 of these cases were doing well and had undoubtedly been saved by this intervention.⁹²

McGregor was convinced of the importance of surgical interventions at MDSs for those who would not otherwise make it to a CCS. He concluded: "I am strongly of the opinion that there should be a special transfusion team with each Division and that this team should work at the MDS or if possible even at the ADS."⁹³

Similarly, in his war diary from 4 July 1918, Colonel Barber, DDMS Australian Corps, wrote: "Three Blood Transfusions (citrated blood) done at MDS which probably saved the lives of these patients. Will endeavour to develop [sic] this as far forward as possible under varying circumstances."⁹⁴ Major General O'Keefe's opposition to medical interventions in forward areas had seemingly failed to dampen Barber's enthusiasm. Two weeks later Barber recorded that he had visited the British No. 5 Casualty Clearing Station,

⁹⁰ Lieutenant Colonel RS McGregor, 'AAMC Narrative of Operation of 4th July 1918', 7 July 1918, War Diary Appendix 11A, ADMS 4th Aust. Div. – July 1918, AWM: AWM4 26/21/26.

⁹¹ Alan Worsley Holmes à Court, NAA: B2455/HOLMES-A-COURT AW MAJOR/5823194.

⁹² Lieutenant Colonel RS McGregor, 'AAMC Narrative of Operation of 4th July 1918', 7 July 1918, War Diary Appendix 11A, ADMS 4th Aust. Div. – July 1918, AWM: AWM4 26/21/26.

⁹³ Lieutenant Colonel RS McGregor, 'AAMC Narrative of Operation of 4th July 1918', 7 July 1918, War Diary Appendix 11A, ADMS 4th Aust. Div. – July 1918, AWM: AWM4 26/21/26.

⁹⁴ Colonel GW Barber, War Diary 4 July 1918, DDMS Australian Corps – July 1918, AWM: AWM4 26/17/7.

which was the one to which casualties in the Australian sector were being evacuated, and he had discussed the transfusion of citrated blood at Main Dressing Stations (MDSs) with Major Gordon Taylor of the RAMC, Consulting Surgeon to the Fourth Army.⁹⁵ These ideas were then developed further and a Blood Transfusion Team was formed for the Battle of Amiens in early August 1918. This team of four was led by Major Holmes à Court and was stationed behind the line at St Acheul. It was available on demand to the Officers Commanding Main Dressing Stations in the Australian Corps.⁹⁶

Major Holmes à Court wrote a report on the work of the surgical resuscitation team at the Battle of Amiens. In it he advocated for a further expansion of the scheme. He wrote:

A study of the records renders it obvious that energetic resuscitation in the forward area accompanied where it is necessary by surgical interference ... as well as blood transfusion and the judicious use of Gum Arabic Solution, has been the direct means of saving many lives.⁹⁷

Over the course of the Battle of Amiens, Holmes à Court's team treated sixty patients and maintained the doctrine that had developed earlier in the development of the scheme. He wrote:

It is to be borne in mind that at all times the class of cases treated includes only the most seriously wounded and those considered unfit to evacuate immediately to the CCS and which would in all probability die being unable to withstand the further journey without receiving immediate treatment.⁹⁸

He suggested that a surgical resuscitation team working within this framework of only treating those men who would not survive the transport to the CCS (shattered limbs, haemorrhages, severe shock) and not impeding the evacuation of the vast majority of cases, could be stationed at the Main or Advanced Dressing Station and save many lives. When not needed for surgery or transfusions the members of the team would then also assist in the general work of the medical post.

⁹⁵ Colonel GW Barber, War Diary 17 July 1918, DDMS Australian Corps – July 1918, AWM: AWM4 26/17/7.

⁹⁶ Colonel K Smith, '4th Australian Division Medical Arrangements No. 1', 5 August 1918, War Diary Appendix 9, ADMS 4AD – August 1918, AWM: AWM4 26/21/27.

⁹⁷ Major AW Holmes à Court, 'Report of Surgical Resuscitation Team', Appendix 6E, DDMS Australian Corps – August 1918, AWM: AWM4 27/17/8.

⁹⁸ Major AW Holmes à Court, 'Report of Surgical Resuscitation Team', Appendix 6E, DDMS Australian Corps – August 1918, AWM: AWM4 27/17/8.

This medical intervention was contrasted with other ideas around medicine forward of Casualty Clearing Stations, which emphasised minimal intervention and rapid evacuation to treatment further down the line. However, it was formalised in the Australian Corps on 21 August 1918 when Colonel Barber wrote a memorandum on the 'Establishment and Equipment for Divisional Resuscitation Teams in the Australian Corps'. The memorandum was sent to the Major General O'Keefe, Director of Medical Services (DMS) for the Fourth Army and Surgeon General Sir Neville Howse, DMS AIF, was also sent a copy.⁹⁹ In the cover note Barber informed O'Keefe that one team was already established and a second would soon be in place. Barber outlined this new formation, known from this point as Divisional Resuscitation Teams rather than the different names used previously. These teams included two Medical Officers, a major capable of doing the surgical work, blood transfusions and resuscitation and a captain who could administer Nitrous Oxide and Oxygen and be able to classify blood donors, as well as Other Ranks including one Non-Commissioned Officer to work in the theatre. Barber outlined the equipment provided for each team, including a Motor Ambulance Car to be provided as needed by the relevant Division. While there were only two existing or being formed at this point (3rd and 4th Australian Divisions), Barber provided for five teams, one for each of the Australian Divisions.¹⁰⁰

The Australian Corps was withdrawn from the line in October 1918 and work began immediately to train further men for work in the resuscitation teams. On 14 October Holmes à Court led a meeting of the 'Resuscitation Committee'.¹⁰¹ This committee included Holmes à Court and the RAMC's Consulting Surgeon to the Fourth Army, Major Gordon-Taylor as joint Presidents, as well as the Medical Officers from each Australian Division who would work in the Divisional Resuscitation Teams. Their report was distributed widely included to the General Officer Commanding (GOC) AIF, GOC Australian Corps, Director General of Medical Services for the British Armies in France, DMS Fourth Army, and to the DMS AIF. In the report the committee outlined the principles upon which the scheme was based, the type of medical interventions carried out

⁹⁹ Colonel GW Barber, DDMS Australian Corps to DMS Fourth Army, 21 August 1918, War Diary Appendix 6, DDMS Australian Corps – August 1918, AWM: AWM4 26/17/8.

¹⁰⁰ Colonel GW Barber, DDMS Australian Corps, 'Memo on Establishment and Equipment for Divisional Resuscitation Teams in Australian Corps', 21 August 1918, War Diary Appendix 6, DDMS Australian Corps – August 1918, AWM: AWM4 26/17/8.

¹⁰¹ Colonel GW Barber, DDMS Australian Corps, War Diary 14 October 1918, DDMS Australian Corps – October 1918, AWM: AWM4 26/17/10.

and the rates of success, including some case notes.¹⁰² Major Gordon-Taylor, the RAMC's Consulting Surgeon to the Fourth Army furnished his own report on the work of the AAMC in this field. He stated:

Several months experience in the Casualty Clearing Zone behind the Australian Corps has enabled me to form an estimate of the excellent work of the Resuscitation Teams of that Corps. There can be no room for doubt that very many lives have been saved by the work of Major Holmes à Court and the members of the other Resuscitation teams. Their experience in the Dressing Stations coincides with that of the Casualty Clearing Hospitals that in Blood transfusion we have the most remarkable and valuable means of treating severe cases of shock and haemorrhage. Their results conclusively prove the value of these methods of resuscitation in the Field Ambulances.¹⁰³

The support of the Consulting Surgeon for the Fourth Army may have helped in the development of the resuscitation teams as the 1st, 2nd and 5th Australian Divisions each sent their resuscitation teams to a different British Casualty Clearing Station for twenty-one days training from 1 November 1918 and the 3rd and 4th Divisional teams were due to under go further training in January 1919; however, the end of the war made this redundant.¹⁰⁴ Major Holmes à Court was Mentioned in Despatches in December 1918 for his work on resuscitation in forward areas and he was awarded the French *Medaille des Epidemies (en argent)*.¹⁰⁵

Maintaining Control: The AAMC in 1918

Unlike the years preceding it, 1918 was not a year of drastic change in the way the Australian Army Medical Corps managed the sick and wounded of the Australian Corps. The most significant change was one of circumstance, from a form of stagnant trench warfare to open, mobile warfare. This difference required the medical services to once again alter the medical arrangements for Australian soldiers. As a result, the Deputy and Assistant Directors of Medical Services in the Australian Corps had to unwind and undo

¹⁰² Resuscitation Teams Committee, 'Australian Corps: Divisional Resuscitation Teams', War Diary Appendix 2, DDMS Australian Corps – October 1918, AWM: AWM4 26/17/10.

¹⁰³ Major Gordon-Taylor, Consulting Surgeon Fourth Army, 'Report of Consulting Surgeon Fourth Army', War Diary Appendix 2, DDMS Australian Corps – October 1918, AWM: AWM4 26/17/10.

¹⁰⁴ Colonel GW Barber, DDMS Australian Corps, 'Australian Corps: Medical Instructions – Routine No. 17', 19 October 1918, War Diary Appendix 2, DDMS Australian Corps – October 1918, AWM: AWM4 26/17/10.

¹⁰⁵ Alan Worsley Holmes à Court, NAA: B2455/HOLMES-A-COURT AW MAJOR/5823194.

many of the reforms that they had made in 1916 and 1917. They did this themselves and were able to make those decisions based on the experience and knowledge built up over three years of war. The most innovative change made by the AAMC, the development of the Divisional Resuscitation Teams, while valuable to the AIF, did not alter the fundamental structures of the medical services, nor did it change the way the vast majority of sick and wounded soldiers interacted with the AAMC. The creation of an Australian Corps and the acceptance of civilian medical expertise at the highest levels of the British Army helped to ensure that the Australian medical men were able to make decisions without interference from those outside of the chain of command. By mid-June all Officers at Division and Corps level were men who had enlisted in the AIF and the AAMC had established itself and consolidated its position as a competent service able to work for its Corps and in cooperation with the broader Allied forces.

Chapter Four

The Purpose, Place, and Practice of AAMC Auxiliary Hospitals

In November 1914 an Australian couple living in Middlesex, England, Mr and Mrs Charles Billyard-Leake, offered their house for use as a convalescent home for sick and wounded Australian soldiers recovering from injury. That offer was accepted and their house and its grounds, Harefield Park, became a convalescent hospital before eventually becoming 1st Australian Auxiliary Hospital (1AAH), Harefield. It was originally intended to house fifty to one hundred patients plus staff, but eight months after opening the accommodation had been increased to provide a thousand beds for convalescing soldiers. While at least one soldier mused that its purpose was to house those who were not “fit to die in their own homes”, its main function was to rehabilitate sick and wounded soldiers for a return to duty.¹ The hospital eventually included surgical, medical, x-ray, massage, electric therapy, as well as recreation and study departments, and, along with the other auxiliary hospitals in the Australian network – 2nd Australian Auxiliary Hospital (2AAH), Southall, and 3rd Australian Auxiliary Hospital (3AAH), Dartford – it formed an integral part of the medical services provided to Australian soldiers wounded in the First World War. Each of these developed specialty areas of medical care with 2AAH becoming the prime location for admitting soldiers in need of prosthetic limbs and 3AAH specialising in war neuroses, shell-shock, and ‘nervous conditions’. The hospital at Harefield specialised in eye, ear, nose, and throat problems, as well as taking general cases in need of further medical care.

The first three chapters of this thesis have examined the transgression, subversion, and eventual blending of imperial, military and medical hierarchies in order to provide efficient and high quality medical care to Australian soldiers in battle. This chapter shifts well behind the lines to evaluate the rehabilitation of Australian soldiers in Australian Auxiliary Hospitals. While historians have previously discussed the role of gender in the forward areas, the focus has been on the disruptions to traditional conceptions of the patients’ masculinity.² Given that this thesis focuses on the providers of medical care, the

¹ ‘Hospital Rules’, *The Harefield Park Boomerang* (hereafter *The Boomerang*) 1, no. 8, (4 April 1917): 4, Australian War Memorial (hereafter AWM): AWM081392 TROOPSHIP SERIAL/The Harefield Park Boomerang.

² Jessica Meyer, *Men of War: Masculinity and the First World War in Britain* (Basingstoke: Palgrave Macmillan, 2011); Bourke, *Dismembering the Male*; Carden-Coyne, *The Politics of Wounds*; Wendy Gagen, “Remastering the Body, Renegotiating Gender: Physical Disability and Masculinity during the First World War, the Case of J. B. Middlebrook,” *European Review of History: Revue Européenne D’histoire* 14, no. 4 (December 2007): 525–41.

discussion of masculine identity thus far has revolved around the transgression of imperial and military hierarchies in order to establish the expertise and authority of Australian civilian doctors in the military. Evaluating the work of the Australian Auxiliary Hospitals in England necessitates the inclusion of gender as a category of analysis because of the increased influence of women in these spaces. Consequently this chapter argues that the blended hierarchy found in the first three chapters is transported to Auxiliary Hospitals in England and is applied to the work done by women in the hospital, privileging the Australian women with medical training over other women, but reinforcing the gender hierarchy with them still subordinate to men. Thus, women were permitted to participate in the “culture of caregiving”, as Reznick has described it, so long as they did not disrupt the traditional conceptions of ‘women’s work’, or, if they did, they were peculiar in their utility to the Australian cause of efficient and effective medical care.

Historians such as Stephen Garton and Marina Larsson have tended to consider the rehabilitation of Australian soldiers as an after-war issue, frequently pairing the discussion with repatriation, pensions, and the treatment of disabled ex-servicemen rather than with the provision of medical care to sick and wounded soldiers during the war.³ The historiography of the rehabilitation and medical care of wounded British soldiers away from the battlefield demonstrates similar framing and lines of enquiry.⁴ Given the lasting impact of the war on both the men who fought and the countries that sent them, this framing of the discussion has significant merit. For many men their wounding was the first event in the process of casualty evacuation, treatment, rehabilitation, removal to Australia, and return to civilian life; a life often supported by family, charitable organisations, and war pensions provided by their government. However, for large numbers of sick and wounded soldiers their stay in an auxiliary hospital assisted in their recovery before their return to the front or, if deemed unfit for active service, to a medical or administrative role. In the First

³ Stephen Garton, *The Cost of War: Australians Return* (Melbourne: Oxford University Press, 1996); Marina Larsson, “Restoring the Spirit: The Rehabilitation of Disabled Soldiers in Australia after the Great War,” *Health and History* 6, no. 2 (2004): 45–59; “Families and Institutions for Shell-Shocked Soldiers in Australia after the First World War,” *Social History of Medicine* 22, no. 1 (2009): 97–114; “Who Picks up the Pieces?,” *Melbourne Historical Journal*, no. 37 (2009): 25; *Shattered ANZACs: Living with the Scars of War* (Sydney: UNSW Press, 2009).

⁴ Seth Koven, “Remembering and Dismemberment: Crippled Children, Wounded Soldiers, and the Great War in Great Britain,” *American Historical Review* 99, no. 4 (October 1994): 1167; Bourke, *Dismembering the Male*; Meaghan Kowalsky, “‘This Honourable Obligation’: The King’s National Roll Scheme for Disabled Ex-Servicemen 1915–1944,” *European Review of History: Revue Européenne D’histoire* 14, no. 4 (December 1, 2007): 567–84; Julie Anderson, *Soul of a Nation: War, Disability and Rehabilitation in Britain* (Manchester: Manchester University Press, 2011).

World War, a soldier's admission to an auxiliary hospital did not necessarily signify the end of his military service.

Two cultural historians of the First World War have sought to locate the study of rehabilitation within its wartime context highlighting the voices of both the carers and the cared for. Jeffrey Reznick discusses British caregiving in four stages in the casualty process: in rest huts behind the lines, in military hospitals, convalescence, and rehabilitation.⁵ Ana Carden-Coyne works within broader parameters and critiques relationships of medical power across the full casualty evacuation chain from site of wounding through to rehabilitation, including on transports, for both British and Dominion medical services.⁶ Reznick argues that the culture of caregiving shaped the wartime experience of both soldiers and civilians. For soldiers this enabled a "comradeship of healing" that was in addition to the comradeship developed in the trenches, highlighting their separation from the rest of society despite the ability of civilian society to participate in and contribute to caregiving. For civilians, participating in caregiving "served as a means to express appreciation of Tommy despite the existence of a true gulf in experience".⁷ Carden-Coyne discusses power dynamics in the rehabilitation process and linked the Foucauldian concept of the 'biopower' of military medicine (i.e. how "medicine and its institutions discipline bodies") to the patients' experience of war wounds arguing that these are not irreconcilable.⁸ In doing so, Carden-Coyne articulates the need for analyses of the interactions between the patients' experience of wounding and the social and political networks of military medicine within hospitals and medical spaces and noted the gendering of the patients in these spaces.⁹ This chapter examines those networks, including the civilian women who participated in the caregiving to Australian soldiers, within 1AAH, Harefield, and their effects on the care provided to wounded servicemen.

The care providers and the care work in the auxiliary hospitals were also gendered, yet are less commonly discussed in the historiography. This gap is partly due to the confluence of two trends in the broader historiography. Historians, including Carden-Coyne, have heeded Roy Porter's call to return to patient perspectives and have done so at

⁵ Reznick, *Healing the Nation*.

⁶ Carden-Coyne, *The Politics of Wounds*.

⁷ Reznick, *Healing the Nation*, 137.

⁸ Carden-Coyne, *The Politics of Wounds*, 13.

⁹ Carden-Coyne, *The Politics of Wounds*, 13.

a time when cultural historians have renewed their focus on discussions of power in the First World War.¹⁰ This gap is also partly due to analyses of rehabilitation during the war having been written about the British experience. British auxiliary hospitals were associated with military hospitals in Britain and were under the control of the military but their day-to-day management was the responsibility of charities including the Red Cross and the YMCA. While the base of Australian operations remained in Australia, the auxiliary hospitals were set up in Britain to keep soldiers closer to the front. Consequently the Australian auxiliary hospitals were under the authority and management of the Australian Army Medical Corps (AAMC). The militarisation of this space placed Australian medical men in charge of medical care while the ‘women’s work’ of nursing, social and domestic care was done by women through the Australian Army Nursing Service (AANS), Voluntary Aid Detachments (VADs), charities, ‘lady volunteers’, and paid staff from the Women’s Auxiliary Army Corps (WAAC). While the work and role of physiotherapists complicated this, I suggest that the Australian model, which emphasised the return of sick and wounded soldiers to duty, increased military authority in this civilian-influenced medical space and harnessed the labour of women without substantial disruption to gender norms.

Examining rehabilitation more broadly, Kate Blackmore analyses the similarities between the processes of return to duty during the war and the assessment of injury and determination of pension entitlements after the war.¹¹ She examines the intersection of war, medicine, and the Australian state from the beginning of the First World War until 1935 through the medical boarding process and the war-pensioning process and notes that economy – of men in the case of medical boarding and of money in the case of pensions – was the underlying factor in both processes. She argues that pensions were not a welfare benefit but were “compensation payments for human damage which resulted from a labour relationship between an individual and the state”.¹² Viewing doctors as instruments of the state, Blackmore notes that the soldier’s body was under surveillance from the moment he enlisted and that the desire for more ‘effective’ troops (soldiers being classified as either effective or wastage) required the ‘reconditioning’ of invalids to be fit for some form of

¹⁰ Carden-Coyne, *The Politics of Wounds*, 10; Roy Porter, “The Patient’s View: Doing Medical History From Below,” *Social Theory* 14 (1985): 175–98.

¹¹ Blackmore, *The Dark Pocket of Time*, 87.

¹² Blackmore, *The Dark Pocket of Time*, 213.

service. Thus, doctors were integral to maintaining the efficiency of the army through rehabilitation and assessments of fitness for duty.¹³

Danny Dawson, British historian and resident of the town of Harefield, published two journal articles that examine the Australian auxiliary hospital in the town and its relationship with the town after the war.¹⁴ Some of his work is based upon the pamphlet by Patricia Kaye, *Under an English Heaven*, which provided a narrative overview of limited events at Harefield and was self-published by Kaye, another resident of the town.¹⁵ In his works Dawson describes activities in the hospital and the contribution of the local community to the Australians' care. He emphasises the varied and frequent forms of social care provided, and outlines the Australians' contributions to the Harefield community.¹⁶ These two acts were categorised as thanksgiving and reciprocation. In addition, Dawson discusses commemoration and remembrance in Harefield during the war, immediately following, and up to eighty-five years after the hospital first opened. Dawson's rosy view of interactions at 1AAH Harefield betrays nothing of the soldiers' resistance to the regime of care at Harefield, which some described as a prison.¹⁷ It is also unlikely that the Australians' presence was entirely popular with local residents given that one of 1AAH's mascots, a kangaroo named Jimmy, was "wilfully murdered" having been tied to a tree in the village and "found with his head battered in, and a portion of his tail cut off".¹⁸ Dawson's conclusions about the special regard in which the Anzacs were still held in Harefield in 2003 may be worthy of re-examination in light of more recent events. On Anzac Day 2015, the centenary of the commencement of the Gallipoli campaign and day of commemoration and remembrance in Australia and at Harefield, and again on 22 November 2015, the headstones of the dead Australian soldiers were vandalised and, on the first occasion, someone attempted to saw the flagpole in half.¹⁹

¹³ Blackmore, *The Dark Pocket of Time*, 132–135.

¹⁴ Danny Dawson, "Remembering Australian Convalescents in Harefield," *Health and History* 6, no. 2 (2004): 60–74; Danny Dawson, "The 'Harefield/Anzac Bond': A Study of Thanksgiving and Remembrance in an English Village," *Family & Community History* 9, no. 1 (May 2006): 27–41.

¹⁵ Patricia Kaye, *Under an English Heaven* (self published, 1993).

¹⁶ Dawson, "The 'Harefield/Anzac Bond,'" 28–29.

¹⁷ Lance Corporal W Anderson aka 'Lyon Taemer', 'Hospital-ities', *The Boomerang* 2, no. 6, (June 1918): 96, AWM: AWM081392 TROOPSHIP SERIAL/The Harefield Park Boomerang.

¹⁸ Lance Corporal W Anderson aka 'Lyon Taemer', 'Hospital-ities', *The Boomerang* 2, no. 9, (September 1918): 166, AWM: AWM081392 TROOPSHIP SERIAL/The Harefield Park Boomerang.

¹⁹ "Vandals Target UK's Main Australian War Cemetery," *ABC News*, April 25, 2015, <http://www.abc.net.au/news/2015-04-25/anzac-cemetery-damaged-in-uk/6420474>; "Anzac Grave Stones

In this analysis of rehabilitation in the AAMC, I examine the purpose of auxiliary hospitals for the AIF in the First World War through a discussion of the medical boarding process before evaluating the hospitals as liminal spaces between home and front – spaces in which conflicting ideas about responsibility for medicine and participation in caregiving were played out. These spaces were primarily military hospitals, with the insatiable quest for efficiency resulting in discussions of economies of labour, yet the presence of women in a variety of roles and the hospital's location in a private home created an environment in which domesticity and gender difference were routinely and openly discussed. This resulted in numerous marriages and a discussion of why some women chose to remain single. Finally, I survey the practice of rehabilitation in these hybrid spaces establishing the effect the place of care had on the practice of care and the degree to which women were accepted as actors with expertise. This evaluation of why, where, and how rehabilitative medicine was practiced by the AAMC highlights the pursuit of efficiency in a military-controlled, civilian-influenced medical space, which in turn reveals the controlled participation of women.

Efficiency: The Purpose of Auxiliary Hospitals

Initially 1AAH Harefield was intended to be a convalescent depot that would be a 'rest home' for officers, warrant officers, NCOs, and rank and file soldiers to recuperate after illness or injury. Its secondary purpose was to act as a depot for collecting invalids for return to Australia. In February 1915, the plan was for the depot to hold 150 patients in summer and sixty in winter. On 31 May 1915, Surgeon General William 'Mo' Williams, Director of Medical Services for the AIF in England, informed the British War Office that he had arranged to extend the depot to at least 500 beds and it was then referred to as an 'Auxiliary Hospital' from this point.²⁰ Given that Australia had a relatively small population and did not have conscription it was especially important that soldiers could be rehabilitated and returned to the front.

An indication of the increasing need for efficiency can be found in the changing approach to medical boarding. In this process a sick or wounded soldier would be paraded in front of a panel of doctors (the medical board) who would seek to classify him according to a set of criteria, place an estimate on his recovery time, and predict the extent to which

Vandalised in West London," *ABC News*, November 24, 2015, <http://www.abc.net.au/news/2015-11-24/anzac-graves-desecrated-in-west-london/6967474>.

²⁰ War Diary 28 October 1917, 1AAH Harefield Park – October 1917, AWM: AWM4 26/72/1.

he would recover. Initially, at Harefield, soldiers were classified as fit for general service or either temporarily or permanently unfit for general service, but by February 1918 this had developed into the eight-part system as shown in

Table 4.1. This classification then dictated where soldiers went after they had recovered enough to leave the hospital, with all discharged patients sent to one of the four Australian Command Depots (ACDs). ACDs were located in Wiltshire with one in Sutton Veny and two in Hurdcott, and the final one in Weymouth, Dorset.

Table 4.1: Classification and Disposal of Patients from 1AAH, Harefield²¹

Class	General Service	Home Service	Disposal
A	Fit	-	1ACD, Sutton Veny
B1a	Temp. unfit < 6 months	Fit	1ACD, Sutton Veny/4ACD, Hurdcott ²²
B1b	Temp. unfit < 6 months	Unfit	3ACD, Hurdcott
B2a	Temp. unfit > 6 months	Fit	2ACD, Weymouth
B2b	Temp. unfit > 6 months	Unfit	2ACD, Weymouth, then to Australia
C1	Permanently unfit	Fit	2ACD, Weymouth
C2	Permanently unfit	Temp. Unfit	2ACD, Weymouth, then to Australia
C3	Permanently unfit	Perm. Unfit	2ACD, Weymouth, then to Australia

As can be seen from Table 4.1, the only sick and wounded soldiers who were evacuated back to Australia were those who were either permanently unfit for General Service and at least temporarily, if not permanently, unfit for Home Service, and those who would not be fit for General Service for more than six months and who could not be used on Home Service in that time. Those fit for General Service entered training to return to the fighting units at the front whereas those fit for Home Service undertook less physically

²¹ Surgeon General Neville Howse, 7 February 1918, War Diary Appendix 4, 1AAH, Harefield – February 1918, AWM: AWM4 26/72/6.

²² The less severe cases in this category were sent to Sutton Veny, the more severe cases to 4ACD, Hurdcott, War Diary Appendix 4, 1AAH, Harefield – February 1918, AWM: AWM4 26/72/6.

taxing duties during their recovery including working as orderlies in wards or in administration roles. The only patients to remain in England who could not be put to work in some capacity were those who would be able to return to frontline training in less than six months. In addition to the eight-part classification system, the B1a group was broken down into four further steps that then dictated how much 'graduated training and exercise' the recovering soldiers were expected to do. This ranged from General Swedish Drill and Special Remedial Exercises for those classified B2b, C2 and C3, through to walking four miles and running one hundred yards in both the morning and afternoon, as well as physical training, organised games and digging, and jumping of obstacles for those classified B1a4, the highest classification of those not currently fit for active service.²³ The purpose of auxiliary hospitals was therefore to rehabilitate Australian soldiers and return them to a state of usefulness for the AIF. This fits with the drive in the AAMC to provide effective medical care in an efficient manner. As will be demonstrated in this chapter, in its quest for efficiency, the AAMC constructed a space for rehabilitation that was different to those it was responsible for in forward areas.

Location and Space: The Place of Auxiliary Hospitals

When Australia entered the First World War the decision was made to have the base of military operations for the AIF located in Australia. Given the distance from Europe to Australia it was too inefficient to transport injured soldiers who would likely be fit for service within six months back to Australia, a process that took six weeks only to have to reverse the journey a short time later. These voyages were uncomfortable for the wounded or sick soldier and could exacerbate their conditions. The alternative was for soldiers who would be able to return to some form of duty within six months to be housed in convalescent hospitals in England. Soldiers did not have to return to the same type of work as they had previously undertaken. Many returned as AAMC orderlies or as administrative staff if their condition was such that they could not return to their battalions. This process was different to the systems in place for other British Empire soldiers. British auxiliary hospitals were attached to military hospitals and, though under military control, they were managed by charitable organisations. Britain's provision extended to its Indian soldiers whose invalids were cared for in Brighton including in its famous Pavilion, as well as in Brockenhurst, Hampshire, and in Netley. The suggestion that King George V thought the

²³ Surgeon General Neville Howse, 7 February 1918, War Diary Appendix 4, 1AAH, Harefield – February 1918, AWM: AWM4 26/72/6.

wounded Indian soldiers should be housed there because ‘they would feel more at home’ in its oriental surrounds appears to be apocryphal, though Sir Walter Lawrence, who wrote a report on arrangements for sick and wounded Indian soldiers, thought the building and its surrounds particularly appropriate.²⁴ Canadian and New Zealand soldiers, once they arrived in England from France, were distributed directly among their respective national hospital networks in Britain, though the Canadian soldiers were more easily despatched back to their homeland.²⁵ In contrast, once an Australian soldier was transported to a Casualty Clearing Station in France or Belgium, the AAMC no longer had direct control over the medical care he received. Wounded Australian soldiers joined the British system of casualty treatment and proceeded through British hospitals in Britain for treatment and further surgery before being transported to an Australian Auxiliary Hospital. While the AAMC provided General Hospitals and Casualty Clearing Stations, they were not necessarily allocated to Australian sectors, nor were Australian patients automatically sent there. The Australian choice to maintain military control of a militarised domestic space away from its base of operations and separate from its major hospitals was unique.

Harefield Park was a convenient location for an auxiliary hospital, being only twenty miles from Central London, and 2.5 miles from a railway station, making the transportation of patients to and from the hospital relatively simple. Yet the formation of a military hospital within a private home also posed problems for the AAMC, creating tension between the military and the homeowner at Harefield Park. As mentioned previously, the house was donated by an Australian expatriate couple who lived in England. The agreement was nebulous and it took less than six months for problems to be raised. In a report on the hospital the Commanding Officer, Colonel Hayward, wrote:

It was originally offered to the Commonwealth as a Convalescent Hospital for from 50 to 100 patients – the formal agreement seems to have been loosely drawn, which has given rise to a good deal of difficulty. It was converted, I am given to understand, into a 1000 bed Hospital without the consent of the owners.²⁶

²⁴ Mark Harrison, *The Medical War: British Military Medicine in the First World War* (Oxford: Oxford University Press, 2010), 61–2.

²⁵ Arthur G. Butler, *The Australian Army Medical Services in the War of 1914-1918: The Western Front*, vol. 2 (Canberra: Australian War Memorial, 1940), 427.

²⁶ Colonel WT Hayward, Report on 1AAH, Harefield Park, AWM: AWM16 4364/22/1.

This required structural changes as well as the construction of wards in the grounds surrounding the house. Colonel Hayward suggested much of the tension was due to an unreasonable act by the Australian Minister of Defence. Hayward wrote:

A cause of a good deal of trouble and misunderstanding has been due to the Minister of Defence having practically given Mr Leake a commission which he interpreted as giving him a right to have a say in the management of the Hospital, and he has always taken up the position that the OC and Officers are his guests – this position is untenable. The Commonwealth may be under an obligation to him – the Officers are the servants of the Government and only responsible to the Army Authorities. A great disadvantage has been owing to Mr & Mrs Leake living in such close proximity to the Hospital and so intimately mixing with the patients. While cheerfully admitting that their kind interest and attention to patients has been of value I feel that it has not tended to improve discipline.²⁷

The failure to properly delineate lines of responsibility meant that the owner of the house was in a position to undermine the authority of the AAMC Staff in the hospital. Despite the fact that he owned the home in which the hospital was located that did not give him license to interfere with the running of the hospital. The AAMC respected medical expertise and recognized military and imperial authority unless subverting them could result in substantially greater efficiency and outcomes. Mr Billyard-Leake's donation did not buy him authority in this space, and while the AAMC was happy to make use of his donation, the Australian medical men of 1AAH, Harefield, did not recognise his claim to 'a commission' from the Minister of Defence.

As a result of this problem Hayward made recommendations for the structure of any future agreements between the military and private property owners, writing:

From the experience I have had I feel strongly that if a Government accepts an offer such as was Mr Leake's it should be only on the definite understanding that during the period of occupation the owner should have no interest in it otherwise than according to a definite agreement as to structural concerns or upkeep.²⁸

²⁷ Colonel WT Hayward, Report on 1AAH, Harefield Park, AWM: AWM16 4364/22/1.

²⁸ Colonel WT Hayward, Report on 1AAH, Harefield Park, AWM: AWM16 4364/22/1.

Thus, Colonel Hayward argued for the assertion and maintenance of military discipline and authority in this military-medical space.

The location of this hospital in a private home with routine visits from 'lady volunteers' who lived in the village resulted in a hybrid military/domestic space under military control but fundamentally different to the Australian medical-military spaces found in France and Belgium. While women were present in those spaces, some as far forward as the 2nd Australian Casualty Clearing Station at Trois Arbes, they were in small numbers. In contrast, at Harefield Park, the female staff was not a small subset who kept to themselves. On 31 March 1918, there were 203 men (21 Officers and 182 other ranks from the AAMC) working at 1AAH, Harefield, as well as 197 women (86 on the nursing staff and 111 General Service VADs). That suggests that around half of the staff were women. Since the Hospital kept an all-female massage staff, if they are included in the AAMC totals then even more women were working at 1AAH than a cursory glance at the numbers would suggest. This, of course, does not include the volunteer work done by the local women.

One method used by the AAMC in its attempts to create a more efficient medical service was the increasing employment of women behind the lines in Auxiliary Hospitals. As more and more men were needed on the battlefield much of the work of orderlies in the auxiliary hospitals was handed over to civilians, frequently to civilian women. On 10 July 1917 Lieutenant Colonel Bertram Milne Sutherland, the Officer Commanding 3AAH in Dartford, recorded in the hospital's war diary that he had discussed extending the scope of the employment of 'Woman Labour' in the hospital with General Howse, the Director of Medical Services for the AIF.²⁹ Howse instructed him to investigate the matter and two days later Sutherland wrote to Howse outlining his recommendations based on the findings of a conference he had convened to discuss the matter with the Registrar, Quartermaster, Acting Matron, and the Superintendent of the Women's Auxiliary Army Corps (WAAC) Staff of the hospital. At this stage the WAAC already provided cooks for the kitchens and housemaids for the Nursing Sisters' quarters. Sister Minhennett, Acting Matron, listed the duties the maids would need to undertake in the wards and it was decided that two maids were required in a ward of 46 beds. This number was sufficient for the maids to work the same number of hours as the members of the WAAC who were already employed in the hospital as well as enabling them to have regular time off. The conference members

²⁹ War Diary 10 July 1917, 3AAH Dartford – July 1917, AWM: AWM4 26/74/2.

decided that the heavier work – scrubbing large wards and carrying baskets of soiled linen – would be carried out by fatigue parties from the AAMC.³⁰

Sutherland listed three potential outcomes upon which he based his recommendation. First, he saw the opportunity for substantial financial savings in the weekly cost of wages. The weekly wages and associated costs of employing one Sergeant, two Corporals, and 37 Privates was £106.7s.6d, whereas the cost for one ‘Overseer’, 28 Wardsmaids, and two Housemaids was £16.19s.4d per week. Employing 31 women to do the work of forty men would save the AAMC £89.8s.2d per week or a saving of around 84 per cent.³¹ Sutherland’s second reason for recommending this change to Howse was that it would allow for the men to be redeployed elsewhere or returned to Australia. The final reason given by Sutherland for the recommended change was that “the duties being largely of the nature of Women’s work will be more efficiently performed by women than by a male staff”.³² Sutherland proposed that the maids work in the wards where Sisters were in charge rather than in the Convalescent Wards, which were managed by orderlies at 3AAH. This structure ensured that the civilian women working in the military hospital were managed by women. They would be under the authority of the Superintendent of the WAAC Staff at 3AAH, Miss Gibson, and their day-to-day work was to be completed under the watchful eye of the nurses.³³ Sutherland’s recommendations were therefore based on a three-pronged understanding of efficiency: monetary efficiency, efficiency of manpower and efficiency of work.

The response to Sutherland’s plan for the more efficient use of resources came from Colonel Thomas Griffiths, Acting Commandant of the AIF’s Administrative Headquarters in Horseferry Road, London. Griffiths had enlisted in the colonial military forces in Melbourne in 1890 as a Military Staff Clerk and had over two decades’ experience in army administration.³⁴ He agreed with Sutherland’s recommendation and requested that the Assistant Quartermaster General make the arrangements. Impressed with the potential savings for the AIF, Griffiths wrote:

³⁰ War Diary 10 July 1917, 3AAH Dartford – July 1917, AWM: AWM4 26/74/2.

³¹ Lieutenant Colonel Bertram Milne Sutherland, CO 3AAH, to General Sir Neville Howse, DMS AIF, 12 July 1917, War Diary Appendix 1, 3AAH, Dartford – July 1917, AWM: AWM4 26/74/2.

³² Lieutenant Colonel Bertram Milne Sutherland, CO 3AAH, to General Sir Neville Howse, DMS AIF, 12 July 1917, War Diary Appendix 1, 3AAH, Dartford – July 1917, AWM: AWM4 26/74/2.

³³ Lieutenant Colonel Bertram Milne Sutherland, CO 3AAH, to General Sir Neville Howse, DMS AIF, 12 July 1917, War Diary Appendix 1, 3AAH, Dartford – July 1917, AWM: AWM4 26/74/2.

³⁴ Thomas Griffiths, National Archives of Australia (hereafter NAA): B2455/GRIFFITHS T/4703497.

It is noted from your memorandum that when the scheme has been brought completely into operation, there will be a saving to the AIF of approximately £89 a week, and at the same time a probable increase in efficiency. The experiment will be carefully watched, because if it is found to be successful, it will be valuable in other hospitals.³⁵

After three years of war, when the cost in terms of men, money, and materials was mounting, and in the period between the two unsuccessful conscription plebiscites in Australia, redeploying forty men and saving £89 per week could alleviate substantial strains on the AIF if the efficiencies could be generalised across other hospitals or military units. In praising Sutherland for striving for greater efficiency and innovation, Griffiths wrote:

I am glad to note that you and your Officers are not blindly following the usual routine in the conduct of the affairs of the Hospital without first inquiring as to whether it is the best available under the circumstances.³⁶

The willingness to depart from convention and to question the underlying assumptions of medical organisation and practice is reminiscent of the work of the AAMC in its development of new casualty evacuation procedures, as discussed in the preceding chapters. In the forward areas the innovations were not contained to one unit but were spread among the AAMC's Officers and this occurred behind the lines as well.

This use of civilian women on the non-medical staff of auxiliary hospitals went beyond 3AAH in Dartford. On 23 January 1917 the Officer Commanding 1AAH, Harefield, reported that Administrative Headquarters had agreed to the use of civilian labour in the kitchens instead of Orderly Staff.³⁷ A year later 1AAH followed in the footsteps of 3AAH by bringing in women to staff the hospital. On 4 January 1918 Lieutenant Colonel Yeatman, Commanding Officer of 1AAH, Harefield, wrote to Surgeon General Sir Neville Howse confirming that 42 women were to replace 40 AAMC orderlies as both Ward Orderlies and Labour Staff. He requested a further complement of seven WAACs to act as housemaids and staff at the two houses in Harefield that were rented to

³⁵ Colonel Thomas Griffiths to Lieutenant Colonel Bertram Milne Sutherland, 14 July 1917, War Diary Appendix 1, 3AAH, Dartford – July 1917, AWM: AWM4 26/74/2.

³⁶ Colonel Thomas Griffiths to Lieutenant Colonel Bertram Milne Sutherland, 14 July 1917, War Diary Appendix 1, 3AAH, Dartford – July 1917, AWM: AWM4 26/74/2.

³⁷ Lieutenant Colonel Yeatman, War Diary Appendix 23 January 1917, 1AAH, Harefield – October 1917, AWM: AWM4 26/72/1.

accommodate the female civilian staff.³⁸ Once the civilian women had commenced work in these roles, Lieutenant Colonel Yeatman forwarded a report on the results to Howse. Yeatman wrote:

Under the substitution scheme of women for men, 69 VAD General Service numbers (including administrative and hostel Staffs) have displaced 52 men struck off strength. On the whole the scheme appears to me to be working satisfactorily and I have much pleasure in being able to say that never before have wards and annexes been so clean as at present.³⁹

Thus, the recruitment of female labour to undertake ‘women’s work’ was viewed as a success, yet, as this was a new role, the limits of the VAD Ward Orderlies still needed to be set. These duties were clarified in Routine Orders No. 151 for 1AAH, on 1 May 1918 and recorded in the 1AAH War Diary the following month. These women were to be addressed as ‘Orderly’ and when on duty in the wards they were supervised, instructed, and “helped in every way possibly to learn” by the Sister in charge of the ward. The Sister was permitted to call on the VAD Ward Orderly to assist in nursing serious bed cases but the VAD was not expected to scrub floors, “sponge helpless bed patients”, or do surgical dressings.⁴⁰ The former was undertaken by fatigue parties of AAMC men and the latter two duties were nursing duties. Here, and at 3AAH (with its discussion of duties still to be undertaken by AAMC fatigue parties), distinctions were maintained between those with medical training and those without, as well as the difference between ‘women’s work’ and the heavier labour to be undertaken by men.

Despite the new female labour force undertaking non-medical ‘women’s work’, not all women who were employed in those roles were deemed to be fit to serve at 1AAH, Harefield. In September 1918 Lieutenant Colonel Yeatman wrote to Surgeon General Howse regarding the situation stating: “I wish to bring before your notice the fact that several General Service VADs reporting for duty from Devonshire House, by reason of ill health, have been found to be unsuitable for employment here.”⁴¹ Devonshire house was

³⁸ Lieutenant Colonel Yeatman to Surgeon General Howse, 4 January 1918, War Diary Appendix 1, 1AAH, Harefield – January 1918, AWM: AWM4 26/72/5.

³⁹ Lieutenant Colonel Yeatman to Surgeon General Howse, 4 April 1918, War Diary Appendix 2, 1AAH, Harefield – March 1918, AWM: AWM4 26/72/7.

⁴⁰ ‘Extract from No. 1 AAH Routine Orders No. 151 of 1/5/18 – General Instructions in Respect to the Duties of a VAD Ward Orderly’, War Diary Appendix 2, 1AAH, Harefield – June 1918, AWM: AWM4 26/72/10.

⁴¹ Lieutenant Colonel Yeatman to Surgeon General Howse, 30/09/1918, War Diary Appendix 10, 1AAH, Harefield – September 1918, AWM: AWM4 26/72/13.

the London residence of the Duke of Devonshire and the Cavendish family, the ground floor of which was given over to the British Red Cross Society for the First World War. The women who were the subjects of the letter between Yeatman and Howse had been sent by the British Red Cross Society with existing medical conditions that were exacerbated by work and were given, initially six then, eight weeks of sick leave. This placed a drain on the efficiency of 1AAH and Yeatman wrote to Howse:

I would recommend that as the G[eneral] S[ervice] members reporting here have had no previous experience of the work, a probationary period of one month should be observed, at the end of which time, if suitable as regards health and adaptability the member should be enrolled and receive the Uniform Grant.⁴²

In the same way that some men were unfit for active service, some women were unsuited to this type of work. This had the potential to cause problems for the women. Some may have sought employment as a way to earn their own money, but many needed to find work in order to support their families after the earning capacity of the male members of their kinship group were limited by war injury or death. As men's bodies were constantly reassessed based on their utility for the State, when engaging in paid labour, women's bodies were also subject to this test.

Philanthropy and volunteering were two ways in which members of the British (and Australian) public could participate in and contribute to the war. Fundraising, advocacy, and, as will be seen, involvement in the care and recreation work of auxiliary hospitals were all forms of voluntary war service in which women participated. Jeffrey Reznick argued that, in the British context, this was a form of wartime memorialisation in which "sites of rest, recovery and rehabilitation played their own roles ... becoming foci of public interest in aiding and honouring the manhood of the nation".⁴³ The location of the 1AAH, Harefield, in an English country village resulted in a different form of involvement in the medical provision from the Mother Country. In this instance it was not a military intrusion but a civilian one, borne out of a desire to improve the care for the Australian soldiers and perhaps indicative of the social contract that had formed between soldier and the state, supported by the public and extended to the dominions.⁴⁴ This is exemplified by the

⁴² Lieutenant Colonel Yeatman to Surgeon General Howse, 30/09/1918, War Diary Appendix 10, 1AAH, Harefield – September 1918, AWM: AWM4 26/72/13.

⁴³ Reznick, *Healing the Nation*, 140.

⁴⁴ Harrison, *The Medical War*, 12.

actions of some of the women from the area around Harefield who saw advocating for the hospital's patients as part of their role. "Certain ladies" viewed the rationing and dietary provisions for patients as inadequate and complained. This complaint reached the Australian High Commissioner to London at the time, Sir George Reid, and the War Office sent the Imperial authorities to investigate. The complaint was considered to be "unfounded".⁴⁵

The presence of so many women altered the relationships that developed within the hospital and highlight the differences between the auxiliary hospitals and the medical spaces discussed in the first three chapters of this thesis. A number of patients were married from 1AAH and their brides were often either nurses (who could marry with the permission of their Commanding Officer), VADs, or women from the local area who volunteered at the hospital. Ana Carden-Coyne has discussed the dual nature of these spaces, suggesting that the role of romance and flirtation warrants further investigation.⁴⁶ There were also marriages between doctors and the women in and around the hospital suggesting they also experienced something of domestic felicity in this militarised space.

Marriages from 1AAH, Harefield, were fairly common and were reported in *The Harefield Park Boomerang*, the hospital magazine. In the August 1918 edition of the magazine, in the regular 'Hospital-ities' column, Lance Corporal W. Anderson, writing under the pseudonym 'Lyon Taemer', wrote: "Yet another offensive. This time the marriage microbe has attacked the hospital, and the wedding bells have been having a good time!"⁴⁷ Lyon Taemer then continued, describing the wedding of Private J. Wickham of the Tunnellers Company, then attached to the AAMC, to Miss Ruby Beatrice Freestone of Harefield. He also informed readers of the wedding of Private Stanley Biggins of the Australian Field Ambulance to Miss Kate Lofty of High Street, Harefield. Hospital chaplain Major Terry officiated, the best man was Lance Corporal B. Sergeant and the bridesmaids were Miss Doris Lofty, sister of the bride, and a Miss Dowling, who were both VADs on the staff of 1AAH Harefield. The description includes details of the bride and bridesmaids' attire, the flowers, and the post-ceremony celebrations. In the same issue of the Boomerang the engagement of Lieutenant Edward Whaley Billyard-Leake, son of the owner of Harefield

⁴⁵ Colonel Yeatman, War Diary ../1/1916, 1AAH, Harefield – October 1917, AWM: AWM4 26/72/1, [date as indicated in file].

⁴⁶ Carden-Coyne, *The Politics of Wounds*, 11–12.

⁴⁷ Lyon Taemer, 'Hospital-ities', *The Boomerang* 2, no. 8, (August 1918): 149, AWM: AWM081392 TROOPSHIP SERIAL/The Harefield Park Boomerang.

Park, to Miss Leila Violet Douglas of Mid Lothian was announced. There was also a wedding in August 1917 between Driver L. Kirkley and Miss L.F. Essen, one of the VADs at Harefield. The story includes a photograph from outside the church where local girls, with their weaving sticks, and the staff and patients of the hospital, with their walking sticks and crutches, formed an archway through which the happy couple proceeded to the cars.⁴⁸ Despite being at war and in a military hospital, the setting of the Auxiliary Hospital created space for intimacy and thoughts of domesticity.

Employing women changed the nature of the space and altered the relationship between the carer and the patient. Harefield's environment, in which marriage occurred relatively frequently, drew attention to the single women in the hospital and created a forum for a discussion of marriage. Many of these women were in paid positions with a measure of independence occasioning *The Boomerang* columnist, Lyon Taemer, to ask in his 'Hospital-ities' column why some women chose to remain single. He wrote:

The question why so many women remain single is doubtless best known to themselves, and as men often rush in with their theories it is to women I look for a trustworthy explanation. As we have a large number of female workers on the Staff, will some of them kindly forward me in writing their reasons "Why women remain single?"⁴⁹

Apparently disappointed with the number of responses, Lyon Taemer published three letters, one from a Nursing Sister and two from VADs at Harefield. The provenance of the letters is impossible to determine; it is possible they were not written by female members of the hospital's staff but were instead submitted by men in the hospital or, in fact, made up by the columnist himself. Assuming that they were written by a nurse and two VADs they provide interesting insight into the willingness of the authors to discuss domestic gender roles in this military space.

For example, in response to Lyon Taemer, one VAD simply quoted the words of Ethel Brunner in *The Elopement* stating that she wanted, ideally, a 'husband-companion' but was wary of letting into her life a 'husband-father', a 'husband-visitor', a 'husband-bully', or

⁴⁸ 'A Wedding', *The Boomerang* 1, no. 15, (1 September 1917): 7, AWM: AWM081392 TROOPSHIP SERIAL/The Harefield Park Boomerang.

⁴⁹ Lyon Taemer, 'Hospital-ities', *The Boomerang* 2, no. 6, (June 1918): 97, AWM: AWM081392 TROOPSHIP SERIAL/The Harefield Park Boomerang.

even a 'husband-gaoler'.⁵⁰ In perhaps the most forthright declaration of the three respondents, the Sister stated why remaining single was more attractive than marrying the wrong man. She wrote:

With the flower of the race gone over the seas, there only remain those who are running to seed. A concave-chested male biped, a small salary and a large family – does that sound alluring? To live contentedly on a crust of bread with the alter ego is an easier process in the pages of fiction than in flats in Paddington – but to share poverty in Pimlico with a Class 3 man, who is 'no class' when it comes to morals or ability, is a prospect too dreadful to contemplate with equanimity.⁵¹

Here she acknowledged the problems that faced women interested in marriage during and after the First World War. A large proportion of young men had been killed or seriously injured in the war, and many of those injuries would result in lifelong disability. While the response of the Sister is humorous, and perhaps demonstrates the use of hyperbole, it acknowledged that if she were to marry she may end up the full time carer of a man unable to work, living in a society which frowned upon married women working outside the home. In this instance the Sister may have agreed with the second VAD who responded to Lyon Taemer suggesting that similar thoughts, when coupled with the behaviour of the Australian patients in the hospital, affected the way she interacted with her patients. She wrote:

[I] enjoy my bachelor girl's life too much to give it up. I have many good comrades amongst the men I know, and can enjoy their company extremely, but you Australians want too much, and expect me to fall in love with you, consequently I have to treat you with reserve, frankness, and friendliness.⁵²

These letters from female members of staff in 1AAH Harefield suggest that this hybrid military/domestic space created room for a relatively open discussion of gender roles and that the presence of women in this space altered the relationship between the carers and those for whom they cared. Civilians, especially women, were actively involved in the daily activities at Harefield, unlike in the Australian controlled medical spaces administering care

⁵⁰ VAD, 'Why Women Remain Single', *The Boomerang*, 2 no. 7, (July 1918): 130, AWM: AWM081392 TROOPSHIP SERIAL/The Harefield Park Boomerang.

⁵¹ Sister, 'Why Women Remain Single', *The Boomerang*, 2 no. 7, (July 1918): 130, AWM: AWM081392 TROOPSHIP SERIAL/The Harefield Park Boomerang.

⁵² VAD, 'Why Women Remain Single', *The Boomerang*, 2 no. 7, (July 1918): 130, AWM: AWM081392 TROOPSHIP SERIAL/The Harefield Park Boomerang.

for Australian soldiers on the Western Front. While women were present as far forward as Casualty Clearing Stations, they worked in a limited variety of roles and did not have the same liberties to interact with soldiers in an environment of domesticity.

By understanding place to be a combination of both the geographical location and the social and cultural life of the inhabitants it is possible to view the organisation of 1AAH and its sister hospitals as spaces structured to reinforce gender norms. This environment required the AAMC to balance competing, and sometimes contradictory demands, in this military-controlled, civilian-influenced medical space. In contrast to the medical spaces between the front and the casualty clearing station, auxiliary hospitals were an environment in which civilian women undertook a variety of roles. From working-class roles such as housemaids, cooks, and clerical work, to the more genteel middle-class assistance in letter-writing, socialisation, and needlework of the 'lady volunteers' (to be discussed further in the following section), none of this work challenged society's existing ideas regarding types of work suitable for men and women. As will be seen in the discussion of the practice of medical care in auxiliary hospitals, the work of female physiotherapists went some way toward disrupting those gender roles; however, there were limitations and restrictions placed on those women as well. It is clear from the marriages and discussions of women's choices to remain single that within this military-controlled space, with numerous civilian women working in traditional female roles, a level of domestic relief from the war on the other side of the channel was achieved. This domesticity, when aligned with and not hampering the purpose of the military unit, was permitted to flourish.

Medicine, Massage, & Fancy Work – Practising Care in Auxiliary Hospitals

Working in the midst of this hybrid military/domestic space were the medical services of the AIF. The medical and surgical departments undertook significant work and the massage and electric therapy departments were kept fully occupied. These medical and allied health roles were supplemented by the Department for Recreation and Study, which provided entertainment, comforts, and forms of vocational therapy to the recovering soldiers. The primary concern of the AAMC Officers was the medical care provided to Australian soldiers and the efficiency with which it was provided. While the social care and recreational activities provided by civilians were appreciated by the Medical Officers, their value was framed in terms of warding off idleness and boosting morale rather than because they possessed intrinsic value.

Registrar of 1AAH Harefield, Major James A. Smeal of the AAMC, published a statistical report of the medical work undertaken in the hospital during 1916.⁵³ In the first five months of the year the hospital received the last of the casualties that had been wounded in the Dardanelles Campaign and then from June it started to receive casualties from France. The scale of the work increased over the year with 1548 admissions in the period January to May and 8539 in the last seven months of the year. This reflects both the high rate of injury from the battlefields in France and the fact that the last major battle involving the Australians at Gallipoli was in August of 1915. Of the 9581 discharges from 1AAH in 1916, 3661 (or 38 per cent) were boarded as unfit for active service. However, of these only 1072 were discharged directly to hospital ships and invalid transports bound for Australia. A similar number were discharged to work at Headquarters or as staff for Harefield or other hospitals with the remainder sent to the convalescent depot at Epsom, in Surrey, or one of the Australian Command Depots.⁵⁴

Indicating the nature of the medical work in 1AAH, only ten soldiers died over the course of the year. These ten deaths included multiple cases of tuberculosis, two of cancer, one of pneumonia, and an instance with a shrapnel wound to the skull complicated by septic meningitis. There were a significant number of surgeries performed over the year (863); however, the majority of them were secondary operations in cases where it was necessary to remove sequestra or foreign bodies or where amputations or re-amputations of stumps were required. No soldier was evacuated directly from France to Harefield – they were first treated in British hospitals – so the primary operations were less common but did include interventions due to appendicitis, hernia, and varicocele, and other similar illnesses and conditions that occur irrespective of the state of war.⁵⁵

The condition of the patients as they arrived at 1AAH, Harefield, led the Medical Officers there to question the standard of care provided by the British hospitals that received Australian war casualties from France and Belgium. In a letter to the DMS AIF, Neville Howse, Colonel Yeatman wrote:

⁵³ Major JA Smeal, 'Statistical Report of Work Carried On During 1916', 1 March 1917, War Diary Appendix 3, 1AAH, Harefield – October 1917, AWM: AWM4 26/72/1.

⁵⁴ Major JA Smeal, 'Statistical Report of Work Carried On During 1916', 1 March 1917, War Diary Appendix 3, 1AAH, Harefield – October 1917, AWM: AWM4 26/72/1.

⁵⁵ Major JA Smeal, 'Statistical Report of Work Carried On During 1916', 1 March 1917, War Diary Appendix 3, 1AAH, Harefield – October 1917, AWM: AWM4 26/72/1.

I have to bring under your notice that, in the opinion of the Senior Surgeon of this Hospital, who has reported a number of specific cases to me, many cases admitted to this Hospital on transfer from British Hospitals show evidence of not having had the surgical care of and attention to their wounds which they should have had from Medical Officers.⁵⁶

Yeatman included a schedule of cases that the Senior Surgeon believed to have received substandard care in British hospitals and vouched for the factual accuracy of the details provided. Yeatman viewed the rapidity of the improvement in patients' conditions on arrival and treatment at Harefield as an indicator of the insufficiency of previous medical interventions. He wrote to Howse:

Faultiness of previous treatment is seen by the improvement which takes place in a few days here; Sinuses which have been discharging pus for several weeks, due to the presence of pieces of dead bone, clear up in a week or two after the Sequestra are removed. Fractures, improperly treated and mal-united or in bad position, are corrected. In more than one case the bone at the site of the fracture was found to be projecting through the wound. Drop-foot or Drop-wrist, unsupported by splints, and unnecessary postural deformities, are not unfrequently [*sic*] found to be present.⁵⁷

These problems with the care provision in British hospitals created extra work for the surgical staff at Harefield and were exacerbated by the fact that men transferred to Harefield from British hospitals with lice infected clothing, another issue to be rectified once they arrived at 1AAH.⁵⁸ Yeatman did not complain or even request that Howse investigate these issues further. He kept his superior officer informed regarding issues of concern at 1AAH and left it to Howse to decide if they were problems that warranted further enquiry. Yet once October came, it was obvious that the problem of substandard surgical care in British Hospitals continued. Yeatman once again wrote to Howse:

Of the condition of the Cot cases on arrival here from British Hospitals I wish to again report that there is great room for improvement especially in the method of splinting of limb, and in the treatment of septic bone injuries. A

⁵⁶ Lieutenant Colonel Yeatman to Surgeon General Howse, 8 February 1918, War Diary Appendix 3, 1 AAH, Harefield – February 1918, AWM: AWM4 26/72/6.

⁵⁷ Lieutenant Colonel Yeatman to Surgeon General Howse, 8 February 1918, War Diary Appendix 3, 1AAH, Harefield – February 1918, AWM: AWM4 26/72/6.

⁵⁸ Lieutenant Colonel Yeatman to Surgeon General Howse, 4 February 1918, War Diary, 1AAH, Harefield – January 1918, AWM: AWM4 26/72/5.

large proportion had after an X ray examination to have immediate sequestrectomies performed with most striking results in the improvement of their wounds and general health. The better and more liberal diet they received here undoubtedly conduces largely to this end.⁵⁹

As these latest cases arrived at Harefield little more than a month before the Armistice, any attempts to alter the condition of men on admission to Harefield did not have time to come into force before the hospital stopped receiving new cases in December 1918 and discharged its last casualties in January 1919 before closing the following month.

While these cases of inadequate medical care caused pain and distress to patients they may have provided part of the impetus for commencing 'Clinical Meetings of the Medical Staff'. These began in February 1918 and at the first of them the Senior Surgeon, Lieutenant Colonel Shaw, held a discussion on 'surgical diseases of the knee joint with special reference to displaced cartilages and treatment by appropriate splinting, illustrated by cases' from within the hospital.⁶⁰ Given the statements regarding the inappropriate nature of the splints accompanying some of the new admissions from British hospitals it is possible that this discussion was devised as a corrective so that the Medical Staff had a better understanding of the problems. These meetings were held weekly for the last ten months of the war and two weeks following Lieutenant Colonel Shaw's discussion were filled with one on 'Massage, Ionization and Electrical treatment generally' by Lieutenant Colonel Dennis, head of the Massage and Electrical Department, followed by a discussion of Shell Shock and War Neuroses led by Major Adams, Officer Commanding the 'Shellies'.⁶¹ These clinical meetings were similar in scope and organisation to the Anzac Medical Society in existence during the early days of Australia's participation in the war at Gallipoli and again as part of the broader British medical services on the Western Front.

Physiotherapists, then known as masseurs (male) or masseuses (female), became integral to the rehabilitation of sick and wounded soldiers in Australian auxiliary hospitals during the First World War. They were responsible for more than massage, also providing

⁵⁹ Lieutenant Colonel Yeatman to Surgeon General Howse, 8 October 18, War Diary Appendix 2, 1AAH, Harefield – September 1918, AWM: AWM4 26/72/13.

⁶⁰ 'Clinical Meetings of Medical Staff', 2 March 1918, War Diary Appendix 1, 1AAH, Harefield – February 1918, AWM: AWM4 26/72/6.

⁶¹ 'Clinical Meetings of Medical Staff', 2 March 1918, War Diary Appendix 1, 1AAH, Harefield – February 1918, AWM: AWM4 26/72/6. 'Shellies' was a term of endearment used throughout *The Boomerang* to refer to patients with shell shock. See for example 'Reminiscences and Curiosities', *The Boomerang* 2, no. 10, (October 1918): 185, AWM: AWM081392 TROOPSHIP SERIAL/The Harefield Park Boomerang.

other therapies including Swedish remedial exercises, hydrotherapy, thermal and electrical treatments.⁶² These professionals were university educated men and women who had undertaken a two-year diploma at either the University of Sydney, University of Melbourne or the University of Adelaide. They shared some theory-based biomedical science subjects with medical students and then undertook specialist practical subjects and placements in hospitals and the community. Professor of Physiotherapy Joan McMeeken notes that as the war progressed and the value of physiotherapy to the process of rehabilitating soldiers was increasingly understood, the universities offered short courses to interested recruits so they could serve in the Army Massage Corps.⁶³ These recruits were then required to either cease practice at the end of the war or complete the remainder of the full course. This mirrors some of the changes made to the education of doctors during the war who were able to have their degrees fast-tracked to enable them to serve the Australian Army as qualified doctors earlier than would otherwise have been possible.⁶⁴ Major Smeal, Registrar of 1AAH, Harefield, saw value in the work of the massage corps. In 1916 the electrical treatment and massage department of the hospital completed 21,582 individual treatments on Australian soldiers with 16,832 being hot air and massage and 4750 electrical therapies. Of the work Smeal wrote: “The amount of work offering for this department has always been, until recently, more than the available staff could cope with, but splendid results have been obtained.”⁶⁵

The Army Massage Corps initially included significant proportions of both men and women, creating difficulties regarding rank and status. Nurses were given the rank of honorary officers and as the masseuses were classified as staff nurses they too were treated as honorary officers. In the case of the masseurs, one man in each military district was made a lieutenant and the rest were designated as staff sergeants.⁶⁶ McMeeken noted that *The Age* newspaper argued for commissioned officer posts for masseurs as thirty-three dentists had all been commissioned as lieutenants.⁶⁷ In a further indication of gender divisions among the staff at 1AAH, Harefield, Yeatman wrote to Howse: “That it is a good

⁶² Joan McMeeken, “Australian Physiotherapists in the First World War,” *Health and History* 17, no. 2 (2015): 54.

⁶³ McMeeken, “Australian Physiotherapists in the First World War,” 56.

⁶⁴ Egan, “Nobler than Missionaries,” 212.

⁶⁵ Major JA Smeal, ‘Statistical Report of Work Carried On During 1916’, 1 March 1917, War Diary Appendix 3, 1AAH, Harefield – October 1917, AWM: AWM4 26/72/1.

⁶⁶ McMeeken, “Australian Physiotherapists in the First World War,” 56.

⁶⁷ McMeeken, “Australian Physiotherapists in the First World War,” 56–57.

principle to keep [an exclusively] female massage staff at this Hospital. Masseurs do not work well or happily where the sexes are mixed.”⁶⁸ Sergeants were paid ten shillings per day and lieutenants fifteen per day, while nurses, and therefore masseuses, were paid seven shillings per day. Given the penchant of the Officers Commanding 1AAH for saving money by employing women instead of men, it is possible that cost was an added consideration in the decision to keep an all female massage staff at Harefield.

In order to provide the level of care desired during a peak period, the Medical Officers of the AAMC decided to train up unqualified orderlies to try to lessen the burden on the masseuses. This was deemed preferable to engaging qualified staff from elsewhere, potentially due to the time for new staff to arrive, the cost of employing qualified practitioners, or due to a desire to maintain the harmony of an entirely female massage staff. While male physiotherapists may not have worked happily when the sexes were mixed, male orderlies began to be trained in massage treatments and they were trained by the female Staff who were also treating between 16 and 20 (and occasionally more) patients per masseuse per day. Lieutenant Colonel Shaw, Director of the Massage Department, reported to Lieutenant Colonel Yeatman:

Extra work too has been thrown on the Staff in instructing orderlies in the elements of the work. These men have shewn keenness in their work, but owing to the amount of work to be done it is impossible to give time to them individually, and as they have, at the best, the most elementary knowledge of anatomy and physiology, &c., the amount of skill they can obtain is very limited. Special attention is paid to instructing them as to the harm that can be done by wrong methods.⁶⁹

McMeeken suggests that the idea for using orderlies as masseurs originally belonged to the Australian Director General of Army Medical Services, Surgeon General Richard Fetherston, as early as 1915. McMeeken then asserted that this proposal “angered both medical officers and physiotherapists”, though she did not articulate the ways in which this anger was demonstrated.⁷⁰ As a result of these decisions, Harefield Park saw women with

⁶⁸ Lieutenant Colonel Yeatman to Surgeon General Howse, 7 January 1918, War Diary Appendix 3, 1AAH, Harefield – January 1918, AWM: AWM4 26/72/5.

⁶⁹ Lieutenant Colonel Shaw to Lieutenant Colonel Yeatman, 2 September 1918, ‘Monthly Report – Massage Department’ August 1918, War Diary, 1AAH, Harefield – August 1918, AWM: AWM4 26/72/12.

⁷⁰ McMeeken, “Australian Physiotherapists in the First World War,” 59.

specialist knowledge placed in positions of authority and power over eager men, keen to learn a new professional skill.

In addition to this authority over men in the hierarchy of staff, Ana Carden-Coyne has argued that the masseuse also had authority and power over the male body. Her hands had the capacity and authority to give pleasure, alleviate discomfort, and inflict pain.⁷¹ Masseuses used their previous professional experience to improve outcomes for patients and broaden the education of some doctors. Miss Jennings, a trained physiotherapist and an assistant in the Electrical and Massage Departments at 1AAH, Harefield, introduced a splint to assist patients with facial paralysis.⁷² The splint minimised the problem of injury to the motor nerve, which had an extended recovery time, but without assistance hampered the range and power of motion to the muscles on the other side of the face. Lieutenant Colonel Dennis wrote that the “simple yet effective appliance has been invented and brought to my notice by Miss Jennings”. He continued:

This splint was used before the war by her and has been in use at Harefield for over two years. It consists of a piece of malleable German Silver Wire bent so as to hook over the ear of the affected side and into the corner of the mouth.⁷³

The splint had a range of benefits including being light, unobtrusive, and easy to make; it improved recovery times and was “greatly appreciated by the Patients, who state they feel more comfortable and can masticate much better”.⁷⁴

As has already been described, doctors shared information and formed medical societies for the instruction and discussion of problem cases or new treatments. This splint is an instance of knowledge being shared between a female physiotherapist and a male doctor. Even though Miss Jennings had been using the splint at 1AAH for two years before she showed it to Lieutenant Colonel Dennis, it was not until he wrote about it and discussed it among doctors (while giving due credit to Miss Jennings) that her innovation was recorded in the war diary of 1AAH. Further research into the relationship between the practice and practitioners of allied health and medicine in the First World War would

⁷¹ Carden-Coyne, *The Politics of Wounds*, 12.

⁷² Lieutenant Colonel CE Dennis, ‘A Simple Splint for Facial Paralysis’, 3 July 1918, War Diary Appendix P1, 1AAH, Harefield – June 1918, AWM: AWM4 26/72/10.

⁷³ Lieutenant Colonel CE Dennis, ‘A Simple Splint for Facial Paralysis’, 3 July 1918, War Diary Appendix P1, 1AAH, Harefield – June 1918, AWM: AWM4 26/72/10.

⁷⁴ Lieutenant Colonel CE Dennis, ‘A Simple Splint for Facial Paralysis’, 3 July 1918, War Diary Appendix P1, 1AAH, Harefield – June 1918, AWM: AWM4 26/72/10.

provide insight into whether this was an isolated incident, the result of a curious doctor, or whether there were formal and informal networks that shared knowledge across disciplines in spaces like the auxiliary hospital.

At 1AAH, Harefield, medical care was not the only form of care practised by those in the hospital. Much of the activity at Harefield would be more accurately described as social care. The recreation and canteen department managed the program of activities, which was extensive, with a large proportion of the funding for the program coming from the Australian branch of the British Red Cross Service. These activities were enabled by the AAMC, funded by charities, and staffed by volunteers from the surrounding areas. The department came under the authority of the Commanding Officer of the hospital and was managed by an employee of the Red Cross who was on loan to the hospital.

In the period from 1 June to 31 December 1917 the Recreation and Canteen Department reported that on average 130 men per week visited “various places of amusement”, generally theatres and other cultural attractions in London and the areas around the hospital.⁷⁵ Small parties were also often invited to tea with local ladies and gentlemen who sent their cars to chauffeur the wounded soldiers between the hospital and their houses.⁷⁶ Entertainment was provided every evening in the hospital in the form of concerts, plays, lectures, and cinema. Here the hospital was indebted to the Soldiers’ Entertainment Fund, which sent a concert party every Thursday, the Victoria League, which provided ‘Lantern Lectures’ each Wednesday, and the Australian Red Cross, which sent either a concert or dramatic party on alternate Tuesday evenings.⁷⁷ The remaining nights were paid for by the profits generated from the patients’ canteen, mostly through sales of cigarettes, tobacco, and “useful articles for the patients”.⁷⁸ Recovering soldiers who were too ill to leave their beds had a special ‘Cot Cinema Tea’ provided every Monday with cigarettes, tea, and cakes available “thanks to the generosity of the Medical officers, the

⁷⁵ ‘Record of Work Done by the Recreation & Canteen Department, 1st AAH, Harefield, From 1st June to End of December 1917’, War Diary Enclosed Reports, 1AAH, Harefield – January 1918, AWM: AWM4 26/72/5.

⁷⁶ ‘Record of Work Done by the Recreation & Canteen Department, 1st AAH, Harefield, From 1st June to End of December 1917’, War Diary Enclosed Reports, 1AAH, Harefield – January 1918, AWM: AWM4 26/72/5.

⁷⁷ ‘Record of Work Done by the Recreation & Canteen Department, 1st AAH, Harefield, From 1st June to End of December 1917’, War Diary Enclosed Reports, 1AAH, Harefield – January 1918, AWM: AWM4 26/72/5.

⁷⁸ ‘Record of Work Done by the Recreation & Canteen Department, 1st AAH, Harefield, From 1st June to End of December 1917’, War Diary Enclosed Reports, 1AAH, Harefield – January 1918, AWM: AWM4 26/72/5.

Lady Canteen Workers, and others”. A billiard room, writing room, library, and music room were also available to patients.⁷⁹

As indicated earlier and discussed by Ana Carden-Coyne, ‘fancy work’ was one form of recreation provided to patients (see Figure 4.1). This consisted of instruction in hand embroidery and the intention was “to occupy, amuse, and please the Australian sick and wounded soldiers at Harefield Park”.⁸⁰ Initially, when materials were all provided to patients, the participation rates were low but they increased after patients were charged cost price for thread, with needles, transfers, and canvas provided by the Commanding Officer’s quarterly allowance. Other forms of craft were also encouraged with basket making a common choice and blind patients making string bags.



Figure 4.1: ‘Fancy Work’, Private A.S. Smart, 3AAH – shrapnel wound, right arm.⁸¹

The gendering of the care provided to recovering soldiers has been discussed by Carden-Coyne with a focus on the “infantilizing and feminizing” of the male patients

⁷⁹ ‘Record of Work Done by the Recreation & Canteen Department, 1st AAH, Harefield, From 1st June to End of December 1917’, War Diary Enclosed Reports, 1AAH, Harefield – January 1918, AWM: AWM4 26/72/5.

⁸⁰ Fancy Work, War Diary Enclosed Reports, 1AAH, Harefield – January 1918, AWM: AWM4 26/72/5.

⁸¹ Rehabilitation Embroidery: Private AS Smart, 19 Battalion, AIF, AWM: REL30298; National Archives of Australian (hereafter NAA): B2455/SMART ALFRED SAMUEL/8086584.

through activities including ‘fancy work’, basketweaving and other arts and crafts.⁸² The focus of her analysis is on the British and American soldiers but the same ideas can be applied to the Australian auxiliary hospitals. The Australian War Memorial now holds a number of examples of ‘fancy work’ completed by recovering soldiers and record of the prizes given for the competitions exists in the *The Boomerang*. These therapies were a defence against idleness and Carden-Coyne highlights the difference between these therapies and vocational rehabilitation, which was more akin to re-training for civilian work. She states that the therapeutic value of handicrafts “was largely framed in terms of occupying the mind, averting introspection, and was associated with the industriousness of the work ethic.”⁸³ In discussing the gendered nature of the therapies, Carden-Coyne writes:

They were also regarded as psychologically healing, helping the weary and embattled to regain manhood through a transitional state of feminized becoming, beginning with the gentle, womanly arts. Therapies were framed on gendered lines. Before regaining the masculine grip of bayonets or guns, the patients learned to hand-stitch delicate material and knit woolen items, practices that were associated with women, such as sock-knitting for soldiers.⁸⁴

While not convinced that this process was consciously, or even subconsciously, designed to transition the wounded soldier from sub-human through the feminine to the masculine ideal, it is worth acknowledging that the forms of work available to wounded men, whose movement and bodily autonomy had been curtailed, were those ordinarily belonging to women.

As the patients paid for their materials they kept their finished work with many sending it home to family and friends. Other hospitals with similar programs sold the work when the soldiers had been given the materials as a way of raising funds for other programs in the hospital. The hospital held competitions and exhibitions of work by patients, and visitors to the hospital were often keen to purchase the items on display, but the reports in the war diary of the hospital and in the hospital magazine, *The Boomerang*, indicate that patients rarely parted with their work for money. With most of the work sent home to family and friends the organisers of the program speculated that it would cause:

⁸² Ana Carden-Coyne, “Ungrateful Bodies: Rehabilitation, Resistance and Disabled American Veterans of the First World War,” *European Review of History: Revue Européenne D’histoire* 14, no. 4 (December 1, 2007): 548; Carden-Coyne, *The Politics of Wounds*, 264–9.

⁸³ Carden-Coyne, *The Politics of Wounds*, 265.

⁸⁴ Carden-Coyne, *The Politics of Wounds*, 265–6.

no doubt, as great wonder to those over there, as it does to those who can see the work being done here in England, when one knows full well that buttons sewn on, holes pulled together in socks etc., is the only sort of needle work that most of the Boys have ever done.⁸⁵

Patients also bought up stocks of materials to use when being shipped back to Australia as a way, especially for bedridden 'cot cases', to pass the time on the six week journey. This program was well-known and "Several Hospitals at Home and Abroad ... consulted the 1st AAH fancy work managers on how to start this work."⁸⁶

Fancy work was considered to be a form of occupational therapy. It required coordination, movement and fine motor skills, and could assist those recovering from injury as well as those attempting to develop their non-dominant side in consequence of amputation of their preferred hand. Also, if the embroidery was set up on a frame, one-handed patients were able to participate. The activity received the assent of the medical staff with the hospital war diary recording: "Doctors and Sisters often find the work very beneficial to patients. It seems a pleasant dose of medicine to many of them, and a very cheap one for the authorities."⁸⁷

Auxiliary Hospitals as Sites of Medical-Military Authority

It has been shown, then, that the 1st Australian Auxiliary Hospital, Harefield, was ostensibly a military space, controlled by the Commanding Officer and administered by the Australian Department of Defence in conjunction with the Australian Headquarters at Horseferry Road, London. Yet its location in a private family home, in a genteel area of Middlesex, created an atmosphere of domesticity absent in other Australian medical-military spaces. This, combined with the relative stability of the both staff and patients, created a community unlike those found in Australian medical-military spaces in France and Belgium.

There was very little British military involvement at Harefield. The interactions between the British and Australian militaries were confined to the point at which patients were handed over to the AAMC at Harefield after the Australians had received care in British hospitals. The Australian Commanding Officer of the hospital thought the

⁸⁵ Fancy Work, War Diary Enclosed Reports, 1AAH, Harefield – January 1918, AWM: AWM4 26/72/5.

⁸⁶ Fancy Work, War Diary Enclosed Reports, 1AAH, Harefield – January 1918, AWM: AWM4 26/72/5.

⁸⁷ Fancy Work, War Diary Enclosed Reports, 1AAH, Harefield – January 1918, AWM: AWM4 26/72/5.

Australians did not receive adequate care from the RAMC medical units during peak times, and reported those thoughts to the DMS, but there were no interventions from the British forces into the Australian sphere of responsibility.

British and Australian women played important roles in the daily life of the hospital. Their work was in both paid and voluntary roles, and in roles that required professional medical knowledge as well as those that did not. However, other than the masseuses employed at the hospital, none of these roles disrupted gender norms and were happily agreed to by the Commanding Officers of 1AAH, in part because of the savings made by employing female labour instead of that of enlisted men. While masseuses had a degree of autonomy and authority, and their work was respected, it was still supervised by the male director of the department and they were paid less than men with the same qualification. The initial employment of a mixed physiotherapy staff had placed the gender and military hierarchies in conflict with each other as female physiotherapists, considered honorary officers, technically outranked some of their male colleagues. Creating an all female massage staff then succeeded in promoting unit cohesion, saving the AAMC money, and reasserting the gender hierarchy by ensuring the women did not have authority over men with the same skills. When the female physiotherapists were placed in positions of authority over unskilled men their authority was restricted to their professional realm where their medical knowledge and experience was privileged.

This significant involvement of women in the auxiliary hospital setting, with half the staff and the majority of volunteers being women, created an environment unlike those found in the other types of medical post administered by the AAMC. While Ana Carden-Coyne has argued that the introduction of handicrafts such as embroidery and basket-weaving were gendered, with the wounded soldier required to pass through a transitory, rehabilitative feminised state between wounded asexual and masculine warrior, I argue that it was the work that was gendered in this instance, not the patient.⁸⁸ The activities described, though welcomed by military authorities, were within the realm of 'women's work' and therefore remained under the authority of the recreation department at Harefield Park. Undertaking 'fancy work' was not compulsory and was valued more by those in command for its ability to ward off idleness than for its rehabilitative effects, which, though acknowledged, were not the primary reasons for embracing it. Therefore, at Harefield Park, medical care was provided by Australian military men, assisted by nurses

⁸⁸ Carden-Coyne, *The Politics of Wounds*.

and physiotherapists, and supported by volunteers providing care and recreation in the form of activities in which they had skills. The civilian involvement in the hospital was considerable, yet the military purpose and control of the hospital was maintained and, as a result, care and recreation at Harefield took on a feminine tone.

The 1st Australian Auxiliary Hospital, Harefield Park, was a medical space, under military control with considerable civilian influence. It was a space in which Britons and Australians interacted across official, professional and personal relationships. The physical space in which they lived and worked had originally been a private home and many of the domestic comforts were maintained despite Harefield Park being a military space. This hybrid medical, military and domestic space created an environment in which romantic relationships were able to develop far enough that there were numerous weddings from the hospital over the course of the war. Despite being at war and in a military hospital, the civilian influence at Harefield, when combined with the work of women providing care in varied forms being a matter of routine, created space for intimacy and thoughts of domesticity. In this way, British-Australian interactions in the hospital pushed beyond the official and the professional and entered realm of the personal. While the highest ranked members of the AAMC appear wary of the quality of care provided by British hospitals, this did not trickle down and affect the professional and personal relationships that developed in the hospital. There were, therefore, limits to Australians' distrust of British involvement in Australian medical care.

Jeffrey Reznick argued that the British public participated in a "culture of caregiving" providing care for wounded British soldiers.⁸⁹ However, this was not limited to British soldiers with the British public extending that caregiving to at least one of the Dominions. The generosity of the local community at Harefield was gratefully accepted and embraced by the Australian military authorities so long as they maintained control. All of these strands were held in tension to still deliver control of medical care for sick and wounded Australian soldiers to Australian medical men.

⁸⁹ Reznick, *Healing the Nation*.

Chapter Five

“A startling outburst”: Controlling Venereal Disease in the AIF

In 1915, four months after disembarkation, venereal disease (VD) infected roughly ten per cent of the Australian Imperial Force (AIF) in Egypt.¹ In the Official History Butler described it as “a startling outburst” that resulted in three per cent of the force being “constantly sick”.² Given that a significant number of soldiers were not only incapacitated but were occupying hospital beds that would be needed once combat casualties started to arrive, VD had serious implications for the efficiency of the Australian army and its medical services. On 27 April 1915, two days after the first Australian troops landed at Gallipoli, and once the failure of the Landings to reach their objectives was known, the AIF decided to clear all remaining VD cases from Australian hospitals in Egypt. On 4 May, 261 soldiers with longstanding cases of VD were shipped back to Australia along with a number of soldiers who were medically unfit for service and should not have been enlisted. By the time they arrived in Australia many of the VD-infected soldiers had recovered.³ After an inauspicious start, VD would continue to be a significant issue for the Australian army with Butler describing the outbreak as one “which brought serious and far-reaching consequences and introduced the medical service to its most difficult problem in the war”.⁴

Over the course of the war the AIF had one of the highest rates of VD of any combatant army.⁵ Peter Stanley estimated that 55,000 members of the Australian Imperial Force were treated for VD.⁶ Similarly, David Noonan, who in his statistical analysis of the AIF examined the veracity of Stanley’s estimate as well as his methodology, concluded that 55,000 men were hospitalised on 69,300 occasions – the same number of infected men at

¹ Arthur G. Butler, *The Australian Army Medical Services in the War of 1914-1918: Gallipoli, Palestine and New Guinea*, vol. 1 (Melbourne: Australian War Memorial, 1938), 34, 76.

² Butler, *The AAMS in the War of 1914-1918*, 1938, 1:77.

³ Butler, *The AAMS in the War of 1914-1918*, 1938, 1:188.

⁴ Butler, *The AAMS in the War of 1914-1918*, 1938, 1:74.

⁵ Walter H. Long, President, Local Government Board, to Governor-General of Australia, Sir Ronald Munro Ferguson, 19 October 1917, National Archives of Australia (henceforth NAA): A11803 1917/89/1026. The overall rate of infection is, however, disputed, as is whether Australia was the worst or merely one of the worst offenders.

⁶ Peter Stanley, *Bad Characters: Sex, Crime, Mutiny, Murder and the Australian Imperial Force* (Sydney: Murdoch Books, 2010), 228.

which Stanley arrived.⁷ This equates to at least one in seven members of the AIF being treated for VD at some point during the First World War.⁸ Complicating the statistics is the problem of determining how many soldiers contracted VD before they embarked for war. It is also impossible to accurately assess how many soldiers contracted VD but did not seek treatment, thus concealing their disease, or who sought treatment through private providers. What is clear is that a significant proportion of Australian soldiers were infected with VD, the rate reported was among the highest of the Allied armies, and that it was perceived to be a threat to the effective functioning of the AIF at war.

The prevalence of VD in the AIF has been attributed to a number of factors, the most significant of which were the Australian soldiers' higher rates of pay and their distance from home. Their British counterparts, when on leave from France, were able to go home to family and friends and re-join domestic life for a time. Australian soldiers were much less likely to be able to do so, unless they had family in the United Kingdom. This dislocation and lack of the supposed moderating influence of their friends and family, combined with feelings of loneliness, have been seen as the biggest factors in the high VD rates among Australian soldiers.⁹ This is also demonstrated by the statistics, which show that the place Australians most commonly caught VD was whilst on leave, whether it be in London, Paris, or Cairo.¹⁰ These explanations for the AIF's VD rate do not take into account the opportunities that being further from home created for the medical services in enabling different treatment and prevention options. In an environment in which disease was associated with sin, the AIF's location half a world away from Australia ensured the use of prophylactic treatments was far less visible to a vocal section of Australian society that argued anything other than a moralist approach advocated vice. This resulted in the diminished influence of Australian purity movements when compared to the influence of equivalent British movements, such as the National Council for the Combating of Venereal Disease (NCCVD), on the actions of Britain's Royal Army Medical Corps (RAMC) and the British Army generally.¹¹

⁷ David Noonan, *Those We Forget: Recounting Australian Casualties of the First World War* (Melbourne: Melbourne University Press, 2014), 64–65, 132.

⁸ Noonan, *Those We Forget*, 132.

⁹ Noonan, *Those We Forget*, 134.

¹⁰ Arthur G. Butler, *The Australian Army Medical Services in the War of 1914-1918: Problems and Services*, vol. 3 (Canberra: Australian War Memorial, 1943), 156.

¹¹ Mark Harrison, *The Medical War: British Military Medicine in the First World War* (Oxford: Oxford University Press, 2010), 156.

The Australian army's response to VD changed over the course of the war. It transitioned from a haphazard, unofficial, moralist approach, which cast the soldier as part of the problem, to a systematic, officially-sanctioned, pragmatic approach in which the soldier played a significant role in the solution. This shift was gradual and the army initially tried to change behaviour through punitive consequences before settling on the medical response that remained largely unaltered from 1917. This chapter traces the discussions about sex, soldiering, citizenship, and disease, which occurred in public and private, through official and unofficial channels, and involving combat and medical Officers, as well as their civilian counterparts. Other individuals and purity groups, including the Australian-born New Zealand sexual health campaigner Ettie Rout, were also involved in the discussion. The chapter outlines the changes in the AAMC's policy on the treatment of VD and assesses its success in lessening the burden of VD on the AIF. It demonstrates that both the treatment and prevention of VD were considered medical concerns, in turn minimising the role of religious actors, including army chaplains, and harnessing the personal responsibility of the soldier. This chapter suggests that the scale of the problem and the military context in which it was tackled created the environment for a systematic response and I argue that the AAMC's pragmatic approach to soldiers' sexual health was possible because it did not transgress, but reinforced, existing gender norms.

Sex, Disease and War: A Brief Historiography

The history of sex in the AIF is tied to the history of sexuality in Australia more broadly. Lisa Featherstone examines the history of Australian sexuality using a Foucauldian framework to analyse "the accumulation of bio-political power around bodies, and the resistance to these authorities".¹² She argues that, in the early twentieth century, purity and chastity were increasingly becoming the ideal for both men and women but that attempts to regulate sexuality were gendered. Featherstone demonstrates that men were not expected to uphold the ideal of chastity. This cast women as responsible for the chastity of both men and women, and at fault if the expected standard was not maintained.¹³ In addition, Featherstone argues that in early twentieth-century Australia a shift emerged that cast current and future wives and children as the innocent victims of the diseased male

¹² Lisa Featherstone, *Let's Talk about Sex: Histories of Sexuality in Australia from Federation to the Pill* (Newcastle upon Tyne: Cambridge Scholars Publishing, 2011), 3.

¹³ Featherstone, *Let's Talk about Sex*, 8–9.

body.¹⁴ This change constructed the male body as a site of contagion and charged men as guilty along with the prostitutes and ‘loose women’ from whom they supposedly contracted the disease. Often motivated by a patriarchal Social-Darwinist worldview that attempted to maintain the strength, virility and purity of White Australia, this paradigm shift cast men as protectors of women and responsible for sexual health rather than passive victims of disease. This distinction was exploited by the AAMC in its attempts to combat VD in the First World War.

Frank Bongiorno’s *The Sex Lives of Australians: A History* covers similar territory to Featherstone’s work, though intended for a more general readership.¹⁵ It is less theoretical in its approach and is based largely on personal diaries, newspapers, and secondary literature, creating a narrative overview of the topic. Both Bongiorno and Featherstone’s social histories highlight the significance of the VD problem for the Australian army and the potential consequences for the female populations where soldiers were stationed. Given the scope of the works as wide-ranging histories of sex and sexuality in Australia, neither author examines the military context of VD treatment in detail, nor uses army reports, instructions or handbooks from the vast collections of these held by the Australian War Memorial and the National Archives of Australia. When they do examine the military context, the discussion is framed around soldiers’ experiences and military responses in Egypt. In contrast, this chapter focuses on the AAMC’s response in France and England.

The military context is also on the fringes of a number of feminist histories of VD and Australian attempts to regulate it during the First World War, including works by Philippa Levine, Judith Smart, and Julie Tisdale.¹⁶ Though examining wartime, these histories do not assess the methods used to regulate the behaviour of white dominion troops. Instead they focus on attempts to control women, and non-white colonial soldiers, often through legislation.

Attempts to manage venereal disease in the Allied armies of the First World War have been examined previously, often in reference to the British army. K. Craig Gibson

¹⁴ Featherstone, *Let’s Talk about Sex*, 95.

¹⁵ Frank Bongiorno, *The Sex Lives of Australians: A History* (Melbourne: Black Inc., 2012).

¹⁶ See for example: Philippa Levine, *Prostitution, Race, and Politics: Policing Venereal Disease in the British Empire* (New York: Routledge, 2003); “Battle Colors: Race, Sex, and Colonial Soldier in World War I,” *Journal of Women’s History* 9, no. 4 (1998): 104–30; Judith Smart, “Sex, the State and the ‘Scarlet Scourge’: Gender, Citizenship and Venereal Disease Regulation in Australia during the Great War,” *Women’s History Review* 7, no. 1 (1998): 5–36; Julie Tisdale, “Venereal Disease and the Policing of the Amateur in Melbourne during World War I,” *Lilith: A Feminist History Journal*, no. 9 (Autumn 1996): 33–54.

examines the relationship between sex and soldiering in the British Expeditionary Force.¹⁷ He refutes the idea in the previous historiography that relationships between soldiers and women were one-dimensional transactional relationships usually defined as prostitution. Whilst his emphasis is on sex rather than disease, he argues that the prostitute was not the only source of disease and soldiers also contracted VD from so-called ‘amateurs’, as well as women with whom they were, or thought they were, in a loving, monogamous relationship. Edward Beardsley compares the approaches of the American and British armies to controlling the spread of VD and argues that the American approaches were more successful because of greater scrutiny from those at home and the relatively low influence of religious actors and upper-class moralists.¹⁸ In a similar vein to these histories, Mark Harrison examines the British army’s approach to the problem of sexually transmitted diseases.¹⁹ He analyses the three main approaches to VD advocated by the British army: sexual continence, medically-regulated prostitution and the use of preventive technologies. Harrison argues that the British army’s approach to VD “was symptomatic of the ambivalence of its top brass towards technologies developed prior to, or during, the war”, suggesting that their resistance to innovation prevented the early adoption of new VD treatments including Salvarsan.²⁰ He draws a similar conclusion to Beardsley suggesting that the conflation of military virtue and sexual restraint was partly a result of the women’s and purity movements at home and the history of the British army, which was “intertwined with that of movements for moral reform”.²¹

Michelle Rhoades examined VD independent of the British army in the First World War. She analyses the relationship between disease and French masculinity with particular reference to the effect of America’s entry into the war and that country’s overt attempts to control its soldiers’ sexuality.²² Rhoades argues this threatened the French approach but found that the French army “affirmed that French soldiers had a right to seek sexual interactions with women unheeded, had a duty to produce children for the nation, and that

¹⁷ K. Craig Gibson, “Sex and Soldiering in France and Flanders: The British Expeditionary Force along the Western Front, 1914-1919,” *The International History Review* 23, no. 3 (September 1, 2001): 535–79.

¹⁸ E H Beardsley, “Allied against Sin: American and British Responses to Venereal Disease in World War I,” *Medical History* 20, no. 2 (April 1976): 189–202.

¹⁹ Mark Harrison, “The British Army and the Problem of Venereal Disease in France and Egypt during the First World War,” *Medical History* 39, no. 02 (1995): 133–58; *The Medical War*.

²⁰ Harrison, “The British Army and the Problem of Venereal Disease,” 134.

²¹ Harrison, “The British Army and the Problem of Venereal Disease,” 156.

²² Michelle K. Rhoades, “Renegotiating French Masculinity: Medicine and Venereal Disease during the Great War,” *French Historical Studies* 29, no. 2 (Spring 2006): 293–327.

the state could not interfere in that process, even if Medical Officers knew soldiers also spread disease”.²³ This stark contrast in the approach to VD suggests that a wide-ranging comparative study of attempts to control male sexuality and disease in the First World War, even if just including Allied countries, would provide interesting insights into differing perspectives on sexuality from around the globe. Davidson and Hall’s edited collection *Sex, Sin and Suffering*, goes some way toward filling this gap.²⁴ However, its form as an edited collection that is not specifically comparative or transnational, and its scope, covering all of Modern Europe and a wide timespan, is too broad to adequately analyse the intricacies of the specifically military context of the First World War.

Closer to Australia, Antje Kampf compares the response to VD in the New Zealand army in the First World War to that of the Second World War.²⁵ Kampf notes the relative absence of any discussion in previous literature of male bodies as subject to surveillance and control and argues that the historiography has appropriately gendered the topic given the attempts to regulate the female body with the caveat that an analysis of the effect on men needs to be included in the scholarly conversation. Kampf argues that the original motivation for combatting venereal disease was one of military efficiency and the emphasis only shifted to controlling sexuality once attempts to curtail the impact of VD through medical intervention and education had failed. This led to increasing surveillance, control and punitive consequences.

With many of these authors describing Australia as having one of the worst, if not the worst, record regarding VD it is then surprising that no systematic analysis of VD in the Australian army has been attempted. Peter Stanley’s *Bad Characters: Sex, Crime, Mutiny, Murder and the Australian Imperial Force* examined many of the actions of Australian soldiers that undermine the idea of the virtuous digger.²⁶ His analysis includes VD but focuses on the rates of infection and the situations in which soldiers were likely to contract disease rather than attempts to control it or minimise its effects. In the Official History, Butler discusses VD as it related to military efficiency and also its potential effects on the current and future wives and children of the soldiers. A specialist in obstetrics and gynaecology

²³ Rhoades, “Renegotiating French Masculinity,” 295.

²⁴ Roger Davidson and Lesley A. Hall, eds., *Sex, Sin and Suffering: Venereal Disease and European Society since 1870* (London: Routledge, 2011).

²⁵ Antje Kampf, “Controlling Male Sexuality: Combating Venereal Disease in the New Zealand Military during Two World Wars,” *Journal of the History of Sexuality* 17, no. 2 (May 1, 2008): 235–58.

²⁶ Stanley, *Bad Characters*.

before the war, he was well-placed to comment on the problem.²⁷ Butler was fairly forthright in his discussion of VD, however, whether deliberately or incidentally, this account glossed over many of the punitive consequences and while it demonstrated to the reader that the policies helped slow the rate of infection, it does so without significant analysis of why they worked or why they were allowed to be implemented.

Peter Stanley's work has since inspired Raden Dunbar to further explore the problem of VD in the AIF.²⁸ This popular history, framed around the stories of five soldiers infected with VD and a number of those tasked with curing them, focuses on the Egyptian base in Abassia and on those shipped back to Australia on the *Wiltshire*, and interned at Langwarrin, a military camp on the outskirts of Melbourne. By framing his discussion in this way, Dunbar misses the most significant changes in VD treatment and its effects on the AIF as these occurred in France and England. The limited scope of the book excludes the vast majority of cases contracted and treated in the Australian army. Dunbar also omits any discussion of George Raffan, who, despite being the Principal Advisor on VD to the Director of Medical Services for the AIF and Consulting Dermatologist to the AIF, is not mentioned.

Dunbar does not locate the ideas of Australian sexuality he discusses within their contemporary context, instead applying present-day sensibilities to early twentieth century Australia. He describes the terror of the general population at the idea of soldiers with VD being re-introduced to society without acknowledging that VD was well-known to the population of Melbourne with twelve to fifteen per cent of the population infected by VD at any time.²⁹ Dunbar also uses city-based Presbyterian ministers as his evidence base when discussing the attitude of Australians to VD. Their view should, however, be discussed in the wider Australian context where Lisa Featherstone has demonstrated that sex outside of marriage had been normalised for men; Australians were not as innocent as Dunbar would have us believe.

In contrast, this chapter argues, in line with Kampf and Harrison, that the issue of VD was increasingly medicalised over the course of the war with the AAMC becoming

²⁷ C. M. Gurner, "Butler, Arthur Graham (1872–1949)," in *Australian Dictionary of Biography* (Canberra: National Centre of Biography, Australian National University), accessed July 7, 2016, <http://adb.anu.edu.au/biography/butler-arthur-graham-5444>.

²⁸ Raden Dunbar, *The Secrets of the Anzacs: The Untold Story of Venereal Disease in the Australian Army, 1914-1919*. (Melbourne: Scribe, 2014).

²⁹ Stanley, *Bad Characters*, 36.

responsible not only for curative medicine but also the maintenance of sexual health, an area not necessarily under the purview of the medical corps. Whilst sexual health and illness became the domains of the AAMC, its approach to treatment was systematised and became more regimented, by limiting Medical Officers' ability to use initiative or try innovative treatments, thus signifying a secondary process of the militarisation of medical treatment. This chapter examines the presence of this dual process and highlights the surveillance, control and punishment of soldiers, extending Butler's work to argue that the policies were effective because of the emphasis placed on self-discipline, the removal of punitive consequences for soldiers who sought medical assistance, and the establishment of trust between soldier and Medical Officer. Secondary to this argument, and echoing the work of Lisa Featherstone, this chapter also proposes that the AIF was able to be the location for a pragmatic approach to VD because that approach did not transgress, but reinforced, the dominant gender roles of the time.

"Familiarity with native women", Prophylaxis and Indecision: The Early Days

As already mentioned, the first few months the AIF spent in Egypt were notorious for the rate of VD infection. With the rate of infection in the civilian population of Melbourne thought to be between 12 and 15 per cent it was to be expected that numerous soldiers already had VD before they disembarked in Egypt.³⁰ Some would have contracted it before leaving Australia, others whilst docked in ports *en route*. Under the command of Lieutenant Colonel White, the 2nd Australian Stationary Hospital (2ASH) set up as a VD hospital for Mena Camp and began receiving cases on 26 January 1915. One of the two hospital sections was under the leadership of Major Bernhard Zwar and he gathered statistics through "careful personal enquiries" of the 300 patients under his care.³¹ Of those 300 patients 139 had gonorrhoea, six had syphilis and 155 had genital sores mostly on the *frenum praeputii*. Zwar was convinced that some of those with genital sores would develop further syphilitic symptoms. Of the 300 cases 250 stated it was the first time they had contracted VD and the majority of those cases stated that "they had not previously taken risk of infection, nor had they known the nature of the risk".³² The remaining 50 patients

³⁰ Stanley, *Bad Characters*, 36.

³¹ 'Notes by Major BT Zwar (No 2 Australian Stationary Hospital) upon Venereal Disease in Egypt', Australian War Memorial (hereafter AWM): AWM25 267/26.

³² 'Notes by Major BT Zwar (No 2 Australian Stationary Hospital) upon Venereal Disease in Egypt', AWM: AWM25 267/26.

reported having contracted VD on between one and twelve previous occasions. Out of the 300 patients, 158 had been under the influence of alcohol when they were exposed to infection and 265 of the soldiers had used some form of preventive or prophylactic method. This suggests that the soldiers knew they were at risk of infection even if they did not understand the long-term consequences of their actions or the extended treatment time. It is clear that most of the soldiers realised some risk was involved if all but 35 of them made some attempt at preventing infection. After that initial period Butler reported that the younger soldiers were sufficiently scared of the disease and the “incorrigibles” were already infected.³³

Yet VD continued to be a problem. In early 1915 some individual members of the AAMC assumed responsibility for a number of practices aimed at preventing the spread of VD in Egypt. This included having the Registrar of the 1st Australian General Hospital (1AGH), Major James Barrett, meet soldiers as they disembarked from Australia. He demonstrated the basics of VD prevention to Australian soldiers and they were warned of the dangers of the disease. A circular giving eleven brief pointers on staying well in Egypt was also distributed to soldiers. ‘Hints on Health in Egypt’ was a one-page memo written by New Zealand’s Colonel Neville Manders, Deputy Director of Medical Services for the Australia and New Zealand Army Corps (DDMS, ANZAC), and it covered topics such as clothing, safe drinking water, alcohol consumption and the effects of sun exposure. On the topic of women it stated:

Men must be careful to avoid any attempts at familiarity with native women: because if they are respectable they will get into trouble, and if they are not, venereal disease [*sic*] will probably be contracted.³⁴

This statement highlights the dual construction of women in the fight against VD, as argued by Lisa Featherstone, with the ANZAC soldier advised to avoid respectable women for the woman’s sake and stay away from those who were not respectable for his own sake.³⁵ In this case the respectable woman is clean, innocent and in need of male protection; the profligate is diseased and dangerous.

Members of the AAMC were not the only people who recognised VD as a problem for the Australian army and put in place policies to limit its effects. Butler writes: “the

³³ Butler, *The AAMS in the War of 1914-1918*, 1938, 1:77.

³⁴ Colonel N Manders, ‘Hints on Health in Egypt’, 1915, AWM: AWM27 376/40.

³⁵ Featherstone, *Let’s Talk about Sex*, 95.

moral and patriotic aspects were forcefully put before the troops in a manly and straightforward letter by the Corps Commander".³⁶ Australian soldiers had been encouraged to spend their money in Cairo amongst local traders, however in an attempt to curb the spending of money on prostitutes, the Australians had the limit of what they could withdraw each day reduced to two shillings. In addition to these measures, soldiers who were in hospital with VD were not paid for the duration of the time they were away from their units. This termination of pay also applied to the allowance that was being made available to their next of kin back home, thus making it easier for the family of a soldier to discover his indiscretions whilst away. Once a soldier had been discharged from hospital his full pay was sent to his next of kin until the arrears he had accrued had been repaid leaving a soldier with little money of his own for a significant period. There is little evidence of soldiers' responses to this policy as most did not write letters home or record in their diaries their experience of VD. One famous case has been discussed by Mark Harrison.³⁷ After a major in the British Expeditionary Force discovered that his wife had been informed he had contracted VD, the officer killed himself prompting the British army to alter its stance on the notification of a soldier's VD status. Given that information such as this was readily shared between the Empire's medical services it is possible that this was a contributing factor in the Australian army's later decision to also change its policy.

With the continual arrival of new troops and reinforcements VD became an ongoing problem for the AAMC and, in recognition of that, a conference of senior Medical Officers was held at the Palace Hotel, Heliopolis, on 17 February 1915 "to devise an efficient means of combating venereal diseases in the Australian Imperial Force".³⁸ The attendees were the highest ranked officers of the AAMC in Egypt and included a number of veterans of the South African War. There were no specialists in dermatology or VD in the group, which mostly consisted of general medical practitioners and surgeons, with an ophthalmologist, the Permanent Head of Public Health for South Australia, and a specialist in obstetrics and gynaecology also present. Each of these men would have had some professional experience in treating VD but, at that time, the AAMC did not include a specialist in the treatment and prevention of these diseases. At the conference Surgeon General Williams estimated that around 1000 men in the 1st and 2nd Australian Divisions

³⁶ Butler, *The AAMS in the War of 1914-1918*, 1938, 1:77.

³⁷ Harrison, *The Medical War*, 156.

³⁸ Minutes from Conference of Medical Officers, 17 February 1915, AWM: AWM27 376/201.

were infected with VD on any given day and that a large number were unable to work. Williams noted that the proportion of men sick in the AIF appeared to be higher than in other forces and asked the Medical Officers present to provide him with more precise numbers of those under their command who had contracted syphilis, soft chancre and gonorrhoea.³⁹

The attendees discussed ways to tackle the problem of VD including military assistance, use of prophylaxis, treatment, establishment of convalescent depots, and the treatment location for men affected by chronic or intractable VD. There was broad agreement that convalescent depots should be established away from the military action to alleviate pressure on hospitals, provide infected soldiers with specialist treatment and rest whilst they were recovering, and minimise the use of resources by VD patients close to the fighting. It was noted by Lieutenant-Colonel Brady Nash that a similar process existed in civilian life in Australia where men with gonorrhoea were treated as outpatients or privately by their General Practitioner rather than as admitted patients in hospitals.⁴⁰ The Medical Officers also agreed that those who could readily be returned to duty should remain in Egypt but that those with intractable illness or syphilis, which had an extended recovery time, should be shipped back to Australia. On the topic of treatment there appears to have been little discussion with the Surgeon-General requesting input from the others present and the only recommendation being that gonorrhoea be treated at the acute stage and then men returned to duty. There was some disagreement about whether to include the military authorities in the Medical Officers' efforts to limit the effects of VD. Surgeon-General Williams suggested they seek assistance from the military authorities to place areas containing brothels out of bounds, attach junior Medical Officers to sections of the military police to restrict the movement of those with VD, and mete out punishment to those who risked infection. Colonel Ryan suspected that the brothels would simply be moved if the area in which they were located was placed out of bounds and Colonel Howse, then the Assistant Director of Medical Services for the 1st Australian Division, suggested that there was little point in requesting help from the military authorities "since they have made no efforts to keep Cairo clean in the past, and have no power under the English law to do so".⁴¹ Lieutenant-Colonel Ramsay Smith pointed out to the group that it

³⁹ Minutes from Conference of Medical Officers, 17 February 1915, AWM: AWM27 376/201.

⁴⁰ Minutes from Conference of Medical Officers, 17 February 1915, AWM: AWM27 376/201.

⁴¹ Minutes from Conference of Medical Officers, 17 February 1915, AWM: AWM27 376/201.

was an offence in the American navy to not report exposure to VD, though there is no indication in the minutes that the attendees discussed the application of this policy to the Australian army at this time.⁴² This conference was convened less than four months after the first Australian convoy arrived in Egypt and already the medical services were discussing ways of integrating medical and provost sections of the army in the prevention of VD, suggesting that VD was viewed as both a medical and a disciplinary problem and that multiple discrete approaches would be insufficient.

The most contentious issue discussed at the conference was the use of prophylaxis. Prophylactic treatment, also referred to as 'early treatment', was any form of medical intervention, whether performed by a Medical Officer, Orderly or the soldier himself, after sex but before any visible signs of infection or other symptoms were present. It was distinguished from preventative options, which were at the soldiers' disposal before sex, and abortive treatment, which was necessary after symptoms were visible. The conference discussion centred around two points: whether prophylactic depots would be useful and effective, and whether disseminating information about the risks and effects of contracting VD would have any effect on the behaviour of soldiers. Prophylactic depots, often termed 'early treatment depots' and later 'Blue Light Depots' as they were marked by a blue light, were usually tents within barracks, or rooms within army buildings, to which men were free to report for early treatment and examination. This consisted of an external antiseptic wash, the injection of a ten per cent Argyrol solution into the urethra, smearing the genitals in calomel ointment and 'touching up' any abrasions with pure carbolic acid.⁴³

Williams suggested that prophylactic depots could be established across Cairo and other centres where men spent time on leave. These would be staffed by a Medical Officer who was trained in administering prophylactic treatments and made freely available for soldiers to use. Colonel Ryan was in favour of prophylaxis and thought that 'isolation tents' could be set up in regimental lines for soldiers to be treated upon their return from leave. Howse was sceptical of the suggestion noting that a similar method of early treatment had been implemented on an *ad hoc* basis according to the initiative of the individual Regimental Medical Officers and had not been successful in curbing the rate of infection. Major Wilson suggested that despite Colonel Howse's objections he thought prophylactic depots would be successful if men could be convinced to use them properly.

⁴² Minutes from Conference of Medical Officers, 17 February 1915, AWM: AWM27 376/201.

⁴³ Minutes from Conference of Medical Officers, 17 February 1915, AWM: AWM27 376/201.

Major Barrett was in favour of the use of prophylactic depots because brothels in Cairo had “no conveniences for obtaining personal cleanliness” which was believed to help in the prevention of VD.⁴⁴

There appears to have not been much discussion on the topic of disseminating educational material to the troops. Williams invited the group to discuss whether “circulars couched in plain and sensible language might be issued to the troops conveying to them a knowledge of the risk they run, and the fact that if infected they will take back to Australia a disease which would reduce their value as citizens”.⁴⁵ The only reference to discussion on this topic is from Howse who suggested there was little point in this approach given that instructions about taking precautions had been delivered by Regimental Medical Officers to the men of the 1st Australian Division and it appeared the men had not heeded their RMOs advice and taken preventative action. He also pointed out that, as already mentioned, Major Barrett had distributed circulars on the topic when the 2nd Australian Division arrived in Port Said and the rate of infection in that division was higher than in the 1st Australian Division. Despite a general consensus that something had to be done to curb the impact of VD, outside of agreement on the medical treatment of VD once symptoms were visible, there was no unified position amongst the senior officers of the AAMC on preventative and prophylactic methods of limiting the effects of VD.

Howse’s contributions to the conference discussion were obstructive. He was recorded as offering no suggestions and only stating when an idea had been tried before or when he thought it would not work. Butler credits him with setting up the Australian response to VD, but this idea is untenable and is more a symptom of the hagiographic tendencies of the official medical historian where Howse was concerned. In contrast, historian Kate Blackmore notes that: “Neville Howse made clear his abstemious values regarding alcohol and venereal disease repeatedly in both official and unofficial correspondence.”⁴⁶ Howse was not a supporter of practices he saw as condoning vice and so it is significant that the AAMC eventually instituted those practices under his leadership.

⁴⁴ Minutes from Conference of Medical Officers, 17 February 1915, AWM: AWM27 376/201.

⁴⁵ Minutes from Conference of Medical Officers, 17 February 1915, AWM: AWM27 376/201.

⁴⁶ Kate Blackmore, *The Dark Pocket of Time: War, Medicine and the Australian State, 1914-1935* (Adelaide: Lythrum Press, 2008), 91.

Protecting the “blood purity of the race” and the “flower of Australian manhood”

With no specialist in dermatology or VD, and no agreement on the method to take to lower the rate of infection, a haphazard approach to the problem developed that was heavily reliant on the efforts of the individual Regimental Medical Officers (RMOs). The rate of infection did slow in the months following the conference and then the initial ‘startling outburst’ of VD was superseded as an issue for the AAMC by the commencement of preparations for the Dardanelles Campaign in the Mediterranean. The lack of official records on VD in the months between April and December 1915 suggests other matters were at the forefront of medical minds in the AAMC. Once the Dardanelles Campaign ended and the Australians were evacuated to Egypt, the issue of VD soon reached crisis point and by March 1916 Neville Howse, who had previously rejected the idea as untenable, requested that General Birdwood, the commander of Australian and New Zealand forces, place Cairo out of bounds for Australian soldiers.⁴⁷ The problem was significant enough that Brigadier General Robert Murray McCheyne Anderson, Deputy Assistant Quartermaster General for the Base Depot, wrote to the Prime Minister of Australia directly to draw his attention to the prevalence of VD in the AIF.⁴⁸ In March 1916 the fight against the effects of VD remained focussed on controlling the access men had to alcohol and the provision of other ‘wholesome’ entertainment options, mostly through the Young Men’s Christian Association (YMCA). The army was concerned by any inference that it condoned vice so did not systematically enlist medical approaches to prevention and prophylaxis, instead it continued the moralist line, supplemented by the actions of individual RMOs, and considered controlling access to brothels.

The enlistment of a specialist in dermatology changed the approach to VD taken by the AAMC. George Raffan enlisted in the AIF in November 1915 and was immediately attached to the 1st Australian Dermatological Hospital (1ADH). He was a Fellow of the Royal College of Surgeons, Edinburgh, and held the position of Acting Honorary Physician at the Royal Prince Alfred Hospital in Melbourne. He was a dermatologist and upon enlistment he stated his specialty as ‘syphilology’ making him the logical choice to lead the AAMC’s attempts at combatting VD.⁴⁹ As well as becoming the Officer Commanding

⁴⁷ Surgeon General NR Howse to Lieutenant General Sir W Birdwood, 7 March 1916, NAA: CP359/2 17.

⁴⁸ Colonel RMM Anderson to Hon. WM Hughes, MP, 23 February 1916, NAA: CP359/2 17.

⁴⁹ ‘Addenda to CM Form A22’, NAA: B2455 RAFFAN GEORGE/8023997.

1ADH, Raffan eventually became the Principal Advisor on VD to the Director of Medical Services (DMS) for the AIF. He arrived in Egypt in early 1916 and, after a period of 'special duty to England', authored a report to the DMS AIF, now Surgeon General Sir Neville Howse, on VD in the AIF.

In that report, 'The Incidence of Venereal Disease in the AIF', dated 18 October 1916, Major Raffan outlined for Howse the reasons VD treatment had needed to be reformed, the methods introduced and the results achieved.⁵⁰ Raffan's main reasons for reforming VD treatment included military efficiency and the sheer magnitude of the problem. He stated that 2300 men were in the venereal hospital in Egypt and at least that many were being treated privately in Cairo. His "moderate estimate" was that at least 5000 soldiers were being treated at any one time. Raffan also suggested that the approach to VD be reformed in light of his view that each instance of "irregular sexual intercourse in London is a probable source of infection" and because moral teaching had not "induced men to remain continent from sexual relations".⁵¹ In addition to these reasons, Raffan also viewed VD as a threat to Australian masculinity and Australia's future prosperity. He wrote:

The blood purity of the race is endangered owing to the ravages of uncontrolled venereal disease. The future of Australia is directly menaced because the flower of Australian manhood, the fathers of the next generation, is subjected to infection from syphilis and gonorrhoea.⁵²

Whilst Raffan acknowledged that men at war take risks and engage in behaviours they would avoid in their everyday lives, he constructed all non-marital sex as threatening to Australia's prosperity. This is in accordance with Lisa Featherstone's suggestion that "discursively, sex was often imagined and understood as being about things other than pleasure: about nation, citizenship, reproduction, duty, disease, contagion, immorality and sin".⁵³ As will be seen, linking sex to ideas of good citizenship and duty became a common theme in the information passed on to soldiers about VD.

⁵⁰ Major G Raffan to Surgeon General Sir NR Howse, 'The Incidence of Venereal Disease in the AIF', 18 October 1915, AWM: AWM27 376/170.

⁵¹ Major G Raffan to Surgeon General Sir NR Howse, 'The Incidence of Venereal Disease in the AIF', 18 October 1915, AWM: AWM27 376/170.

⁵² Major G Raffan to Surgeon General Sir NR Howse, 'The Incidence of Venereal Disease in the AIF', 18 October 1915, AWM: AWM27 376/170.

⁵³ Featherstone, *Let's Talk about Sex*, 11.

In the same report to the DMS AIF, Major Raffan also outlined the methods that had been introduced to lower the rate of VD in the AIF. First, soldiers were educated by Medical Officers about the nature and consequences of VD. In a time when many thought that frequent sexual activity was needed to maintain strength and virility, Raffan stated that “They are told that continence is not harmful, and are strongly advised to abstain from all forms of irregular sexual intercourse.”⁵⁴ The men were also told that if they decided to “run the risk of infection” their best protection against VD was to use a ‘French Letter’ – a condom. Soldiers were also instructed in early treatment methods and ‘Nargol Outfits’ were handed out to all soldiers going on leave, though soldiers could refuse them. These outfits, containing calomel ointment and Nargol jelly, were self-administered before and after intercourse and men were informed that, if used, they would not guarantee safety but greatly reduce the risk of infection.⁵⁵

It is doubtful that the discussion of the safety of sexual continence altered the behaviour of many soldiers. The early twentieth century saw increasing attempts to control and restrain male sexuality when doctors and scientists advocated continence in opposition to the commonly held belief that sexual activity was linked to health and vitality. Lisa Featherstone questioned the persuasiveness of the continence narrative stating: “Men often believed that they simply could not control their passions, their hydraulic sexual urges. Many believed women were there for the taking, to salve the ‘animal’ part of man’s nature.”⁵⁶ Here popular opinion stood opposed to the increasing authority of medicine with the male body as a site of conflict. Featherstone also noted the need to continually remind men of the importance of chastity suggesting that the reminders were only necessary if the message had failed to change behaviour. Sexual continence was an oft-repeated theme in lectures and education materials through to the end of the war, which, following Featherstone’s reasoning, suggests that the soldiers were never entirely convinced; however, it is also possible that the AAMC believed this line of argument to be effective and therefore continued its use.

Raffan’s final suggestion for reform at the time of the report was for soldiers to be treated in hospital for VD. No Regimental Medical Officer was to treat a case of VD in the

⁵⁴ Major G Raffan to Surgeon General Sir NR Howse, “The Incidence of Venereal Disease in the AIF”, 18 October 1915, AWM: AWM27 376/170.

⁵⁵ Major G Raffan to Surgeon General Sir NR Howse, “The Incidence of Venereal Disease in the AIF”, 18 October 1915, AWM: AWM27 376/170.

⁵⁶ Featherstone, *Let’s Talk about Sex*, 47.

lines. Rather, his role was to evacuate all “suspicious or actual” cases to a hospital as soon as possible for the Medical Officer there to assess and treat.⁵⁷ At this stage of the war Medical Officers in the lines did not have the time, and most orderlies did not have the training, to adequately treat VD. Cases that reached a hospital within twelve hours of symptoms could be treated using the abortive ‘sealing up’ method, which often ensured men could be returned to duty within a week. All cases where a definitive diagnosis of VD could be made were sent to the VD hospital.⁵⁸ This decision was later reversed with men given prophylactic and abortive treatment in their units and only evacuated to a VD hospital if the abortive treatment failed to cure the disease. Orderlies were trained to provide the treatments and also to staff early treatment depots in order to provide a better chance at success than a treatment self-administered by an untrained and, in many cases, intoxicated soldier.

In order to demonstrate the importance of early treatment Raffan gave the example of a division where preventive methods were actively taught and Nargol Outfits and condoms were distributed to soldiers. In that division 743 men had gone on leave between 10 July and 31 August 1916 and only one man contracted VD. In another instance where preventative methods were not promoted with the same rigour there were 96 cases in one Training Battalion. At the time of writing the report there were 1200 cases in the VD hospital of which an estimated 300 were contracted in Australia, Egypt, France and Cape Town. In the period between 1 August and 18 October 1916, 80,000 Nargol Outfits and 17,000 condoms had been issued to soldiers with 8000 men passing through the Early Treatment Depot in London. Major Raffan concluded his report with the estimate that had these reforms not been made the 900 cases in the VD hospital would have numbered closer to 5000.⁵⁹

Non-government figures attempted to influence the treatment of VD in the Australian and New Zealand armies. Ettie Rout was the head of the New Zealand Volunteer Sisterhood and spent considerable time working to limit the effects of VD on the armies of Australia and New Zealand during the First World War. She gained the

⁵⁷ Major G Raffan to Surgeon General Sir NR Howse, “The Incidence of Venereal Disease in the AIF”, 18 October 1915, AWM: AWM27 376/170.

⁵⁸ Major G Raffan to Surgeon General Sir NR Howse, “The Incidence of Venereal Disease in the AIF”, 18 October 1915, AWM: AWM27 376/170.

⁵⁹ Major G Raffan to Surgeon General Sir NR Howse, “The Incidence of Venereal Disease in the AIF”, 18 October 1915, AWM: AWM27 376/170.

confidence of senior New Zealand and Australian government and army officials and wrote a letter to Colonel Rhodes on 12 March 1916 in which she described the Wasseh district. Colonel Rhodes was a Boer War veteran, Honorary Colonel of the 1st Mounted Rifles and a member of the New Zealand House of Representatives. During the First World War he served as the New Zealand Government's Special Commissioner to Egypt and Galilee where he reported on conditions for the troops and then, in 1916, whilst still a member of parliament, he was based in Europe as the Commissioner of the New Zealand Red Cross. After touring the Wasseh district with a New Zealand gentleman and a guide between 6:30pm and 7:45pm on Saturday 11 March 1916, Ettie Rout wrote to Colonel Rhodes:

Outside notorious brothels long queues of soldiers waited their turn. One open door revealed a stairway with lines of soldiers going up and down – in and out. Soliciting and enticing was quite openly carried on. Bedizened and lustful women thronged the streets and doorways, many of them embraced by soldiers. Doors were open and soldiers could be seen inside the rooms sitting on women's laps or vice versa. Other open street doors revealed beds ready made, or a partition with the doorway inside curtained to hide the inmates temporarily. Our soldiers were in these places.⁶⁰

Rout discussed the role of religious and other civilian groups working with the troops and the level of responsibility these groups should have for minimising VD infection rates. She wrote:

From what I can gather I do not think the religious and other civilian persons working for the good of our troops ... would do anything to embarrass or hinder the military Medical Officers but the decision to sell prophylactics ... or to establish 'licensed houses' must rest with the military medical men. It is wise that measures for the control of sexual desire – such as the provision of wholesome recreation and amusements etc., and the general 'preventive work' of the YMCA – should be directed by such bodies as the YMCA; but measures taken for giving expression to sexual desire, or minimising the dangers of doing so, are no part whatever of YMCA work, though I think it is reasonable to hope they should refrain from any adverse criticism which would embarrass

⁶⁰ Miss EA Rout to Colonel Rhodes, 12 March 1916, NAA: CP359/2 17.

those already burdened with the onus of exceedingly unpleasant responsibility.⁶¹

British Headquarters in Cairo forwarded a copy of Rout's letter to Colonel Anderson at AIF Headquarters in Cairo along with the suggestion that Anderson should help facilitate the development of alternative recreation opportunities for Australian troops, rather than having them visit the Wasseh district.⁶² The majority of the Australian forces were soon moved to the Western Front and as a result the availability of prostitutes and the lack of other, more suitable, forms of entertainment in Cairo became less of a concern for the AAMC and the AIF.

1917: The Shift from Punitive Consequences to a Medical Approach

Changes made in 1917 were crucial in the treatment and prevention of VD in the AIF. New methods were implemented, extra bureaucracy was introduced to streamline the handling of VD cases, and at the Imperial Conference there was a discussion of the temptations encountered by soldiers and actions that could be taken to curtail them. Many of the changes stemmed from Major Raffan's report titled 'Suggested Reform in the Management of the Venereal Disease Problem'. Curiously, Raffan chose to communicate his suggested reforms directly with Birdwood before he discussed them with Howse. Raffan wrote to Howse on 30 October 1916:

Lieutenant General Sir W R Birdwood informed me that he was prepared to investigate a report on 'Reform in the management of the Venereal Disease Problem', subject to such getting the approval of the DMS AIF. I respectfully beg to submit a report on this question for your consideration.⁶³

Assuming that Raffan accurately represented his correspondence with Birdwood, it demonstrates that Birdwood wanted to maintain the existing structures and leave medical care in the hands of the Medical Officers. Birdwood was keen to have Raffan report his suggestions through the appropriate channels and not step outside of the AAMC chain of command to the Corps Commander. Given that a number of the recommendations were ones to which Howse had previously expressed opposition, this may have been an attempt by Raffan to encourage Howse to re-examine his views with the weight of the Corps Commander behind them. If this was Raffan's strategy then he was still partially successful

⁶¹ Miss EA Rout to Colonel Rhodes, 12 March 1916, NAA: CP359/2 17.

⁶² WH George to Colonel RMM Anderson, 14 March 1916, NAA: CP359/2 17.

⁶³ Major G Raffan to Surgeon General Sir NR Howse, 30 October 1916, AWM: AWM15 14379/7.

as he was able to inform Howse that Birdwood was willing to engage with the problem further.

Raffan's attempts to improve the chances of the adoption of his suggested reforms' did not end with trying to enlist Birdwood in his cause. Raffan did not send his report directly to Howse; he first sent it to Colonel Douglas Murray McWhae, Assistant Director of Medical Services for the AIF Depots in the UK. Raffan may have been instructed to do this by Howse as McWhae was effectively Senior Medical Officer (SMO) of the largest number of Australian soldiers most likely to become infected with some form of VD. However, this same reason can explain why Raffan may have thought McWhae would be particularly keen to help change the way VD was treated, medically and in terms of discipline, in the AIF. Raffan wrote to McWhae: "Would you please consider this recommendation and forward same to DMS with opinion & amendments suggested."⁶⁴ This suggests that Raffan also tried to use McWhae's influence to get Howse to adopt the measures. McWhae forwarded Raffan's memorandum, along with his own views, to Howse soon after.⁶⁵

In his memorandum, Raffan outlined the threat posed by VD and then articulated his criticisms of VD treatment up to that point. He wrote again of the dangers to the "blood purity of the race" and his dismay at the "flower of Australian manhood being subjected to infection from syphilis and gonorrhoea" and stated that: "Too large a percentage of the fighting force is rendered unfit for duty owing to infection from disease that is to a large extent preventable."⁶⁶ Regarding the approach to VD taken by the AIF up to this time, Raffan stated:

The penalties and consequences associated with the acquisition of venereal disease have not succeeded in preventing men from taking the risk of getting disease. The only effect has been to induce men to conceal their disease, and when it is ultimately discovered or confessed the golden opportunity of effecting a speedy cure has been lost, and the disease has become chronic.⁶⁷

⁶⁴ Major G Raffan to Colonel DM McWhae, 25 February 1917, AWM: AWM15 14379/7.

⁶⁵ Colonel DM McWhae to Surgeon General Sir NR Howse, 27 February 1917, AWM: AWM15 14379/7.

⁶⁶ Major G Raffan, 'Suggested Reform in the Management of the Venereal Disease Problem', 30 October 1916, AWM: AWM15 14379/7.

⁶⁷ Major G Raffan, 'Suggested Reform in the Management of the Venereal Disease Problem', 30 October 1916, AWM: AWM15 14379/7. Emphasis in original.

The moralist and punitive approaches to VD up to this point had been shown to be ineffective but those Medical Officers who had introduced some measure of preventative, prophylactic or non-punitive abortive treatment saw significantly lower rates of infection than those who did not use those methods. Based on “12 months close association with venereal disease as it affects the AIF” Raffan suggested there were two ways in which VD could be prevented in the AIF. First, men could remain continent or take precautionary measures before they risked infection, alternatively the AAMC could induce “men to report to a Medical Officer [without fear of penalty] as soon as the first symptom of disease develops, so that early treatment can be instituted”.⁶⁸ The AAMC eventually used both of these suggestions in tandem.

Raffan believed there were three principal reasons why men did not come forward and report that they were infected with VD. First, shame and publicity were motivating factors. Raffan wrote: “If a man enters a Venereal Hospital as a patient his relations and friends in Australia get to know of it, and in consequence a man will do anything to avoid this publicity.”⁶⁹ In order to avoid his family and friends finding out Raffan stated:

He seeks advice and treatment from friends, chemists, and other ‘quacks’, who are totally unfitted to cure the disease. The thought of exposure drives him to conceal his disease from his Medical Officers, although it apparently does not stop him from taking the risk of acquiring disease.⁷⁰

In order to remedy this situation Raffan recommended that men who self-report their disease to a Medical Officer at the first sign of disease should not have their names published as being sick in a venereal hospital. He wrote: “With the fear of publicity removed, a certain number of men (in my opinion the large majority) will have no hesitation in reporting at once for examination and treatment.”⁷¹

Regarding the issue of shame, McWhae questioned the veracity of this suggestion in his recommendations to Howse. McWhae wrote:

⁶⁸ Major G Raffan, ‘Suggested Reform in the Management of the Venereal Disease Problem’, 30 October 1916, AWM: AWM15 14379/7.

⁶⁹ Major G Raffan, ‘Suggested Reform in the Management of the Venereal Disease Problem’, 30 October 1916, AWM: AWM15 14379/7. Emphasis in original.

⁷⁰ Major G Raffan, ‘Suggested Reform in the Management of the Venereal Disease Problem’, 30 October 1916, AWM: AWM15 14379/7. Emphasis in original.

⁷¹ Major G Raffan, ‘Suggested Reform in the Management of the Venereal Disease Problem’, 30 October 1916, AWM: AWM15 14379/7. Emphasis in original.

Are the names of men in Venereal Hospital published in any way so that it becomes known to friends, relatives or anybody that they are suffering from Venereal Disease? If not, then the paragraph in his report is inapplicable.⁷²

There was evidently some confusion over whether names were recorded by the army and the level of disclosure to the soldiers next of kin. This is, however, partly explained by the second reason given by Raffan that he thought encouraged soldiers to conceal VD, namely that men incurred financial loss when they reported that they had contracted VD. A soldier with a wife and/or children was required to have a portion of his pay set aside for his family to access while he was away at war. Pay was stopped when a soldier was 'ineffective' because of his own actions so when a relative went to withdraw money and there was none available it was an indication that he was infected with VD (or another self-inflicted wound), was under arrest, or had died. The pay office was, perhaps unsurprisingly, one of the most efficient departments and was therefore one of the first indicators of illness or death for the next of kin.⁷³

Along with having pay stopped once VD was contracted, soldiers also had to repay to the hospital system the cost of their treatment. According to Raffan, this meant that a soldier who was in hospital for six weeks could not draw pay for three months and a soldier in hospital for three months – quite a common occurrence with VD – would not receive any pay they could withdraw for close to six months. Upon discharge from hospital a soldier then faced leave restrictions and would not be eligible for leave for twelve months.⁷⁴ Raffan suggested that these men “lose heart” and become “hardened and sullen law breakers”.⁷⁵ Moreover, they “lose all esprit de corps and their usefulness is greatly impaired, if they do not become utter wasters”.⁷⁶ To alleviate this problem Raffan suggested that soldiers should be ordered to report to their Medical Officer at the first sign of disease. If they failed to do so and were subsequently admitted to a VD hospital, soldiers would then be punished by having their pay withheld, for failing to follow an order rather than punished for contracting VD. Medical Officers were able to tell whether VD was in

⁷² Colonel DM McWhae to Surgeon General Sir NR Howse, 27 February 1917, AWM: AWM15 14379/7.

⁷³ Stanley, *Bad Characters*.

⁷⁴ Major G Raffan, 'Suggested Reform in the Management of the Venereal Disease Problem', 30 October 1916, AWM: AWM15 14379/7.

⁷⁵ Major G Raffan, 'Suggested Reform in the Management of the Venereal Disease Problem', 30 October 1916, AWM: AWM15 14379/7.

⁷⁶ Major G Raffan, 'Suggested Reform in the Management of the Venereal Disease Problem', 30 October 1916, AWM: AWM15 14379/7.

its early stages or if it was chronic so many men could then receive the abortive sealing-up treatment and be fit to fight within a week. The goal of Raffan's suggestion was to "sufficiently punish a man, without totally disheartening him".⁷⁷

Regarding financial loss, McWhae presented arguments both for and against accepting Raffan's recommendations. McWhae's first objection was that the Government would be paying soldiers their full wage when they were in hospital and 'ineffective' due to their own actions and not owing to any injury as a result of military action. He also noted that this would be a significant expense. McWhae then questioned the ability of the Medical Officers to determine whether a soldier had reported at the first sign of disease and suggested that all men would say they sought medical attention at the first opportunity. Conversely, McWhae wrote that Raffan's suggestions would "ensure that a large majority of men will report at once because they lose nothing by reporting sick".⁷⁸

Finally, Raffan argued that ignorance was a significant issue in attempts to prevent the spread of venereal disease. He wrote that the men were "woefully ignorant" of the causes and consequences of VD and believed that a greater understanding of the issue would encourage them to avoid "irregular" sexual intercourse altogether, or else take precautionary measures. His proposed solution was a scheme of education. He suggested:

Systematic instruction to Officers, Warrant Officers, NCO's [*sic*] and men regarding the facts of venereal disease, as well as the imparting of knowledge of the measures that should be adopted to reduce the incidence of disease.⁷⁹

While ambivalent towards Raffan's recommendations regarding financial loss, McWhae adopted in full the suggestions made by Raffan regarding the general level of ignorance amongst personnel in the AIF. McWhae did not make a recommendation to Howse on this matter; instead he simply wrote: "Necessary action taken".⁸⁰

Raffan's continued work on VD drew his attention to the problem created by men going on furlough. On 30 March 1917 Raffan sent McWhae a report titled 'The incidence of Venereal Disease amongst men going on furlough from Australian Auxiliary and British

⁷⁷ Major G Raffan, 'Suggested Reform in the Management of the Venereal Disease Problem', 30 October 1916, AWM: AWM15 14379/7.

⁷⁸ Colonel DM McWhae to Surgeon General Sir NR Howse, 27 February 1917, AWM: AWM15 14379/7.

⁷⁹ Major G Raffan, 'Suggested Reform in the Management of the Venereal Disease Problem', 30 October 1916, AWM: AWM15 14379/7.

⁸⁰ Colonel DM McWhae to Surgeon General Sir NR Howse, 27 February 1917, AWM: AWM15 14379/7.

Hospitals' and asked McWhae, once again, to pass it on to Howse with his comments, which McWhae did on 4 April 1917. In the report Raffan described the size of the problem and outlined new procedures for VD given the existing processes for men going on furlough from hospitals. He wrote:

Considering that 60% of the total amount of Venereal Disease occurs amongst men on furlough from Hospitals, the machinery at present in operation to educate and instruct these men is in my opinion totally inadequate.⁸¹

Raffan recommended that a new system be implemented at Australian Auxiliary Hospitals (AAHs) and at Australian Headquarters at 130 Horseferry Road, London. Raffan suggested that a lecture should be given by a Medical Officer and a Chaplain, who should be "specially appointed to talk to men from the moral and social standpoint".⁸² This lecture was proposed for all men who were due to be discharged within a week and Raffan reported that the combination of Medical Officer and Chaplain had proved successful at No 1 Command Depot. He also recommended that all those discharged on furlough from an AAH be given an 'advice card' that provided information on where an Australian soldier could access early treatment if necessary. Raffan advised that a Medical Officer see every man passing through Headquarters in order to "educate and instruct small groups of men at a time, in the room set apart for the purpose, on the dangers of irregular sexual intercourse and the methods available to prevent or abort venereal disease".⁸³ He suggested that Nargol Outfits and French Letters be issued free of charge and that a box of six French Letters, for a man on fourteen days' furlough, should be sufficient. In order to ensure that all soldiers proceeding on furlough accessed this advice, Raffan proposed that orders be issued stating: "No furlough warrant shall be issued unless a man produces a card of advice with the office stamp and date stamped thereon."⁸⁴ For immediately after furlough, Raffan's suggestions included having a Medical Officer examine every soldier within 24 hours, instructing those who had not used sanctioned preventative methods before intercourse to seek treatment immediately (irrespective of whether there were visible

⁸¹ Major G Raffan, 'Incidence of Venereal Disease Amongst Men on Furlough from Australian Auxiliary and British Hospitals', 30 March 1917, AWM: AWM15 14379/7.

⁸² Major G Raffan, 'Incidence of Venereal Disease Amongst Men on Furlough from Australian Auxiliary and British Hospitals', 30 March 1917, AWM: AWM15 14379/7.

⁸³ Major G Raffan, 'Incidence of Venereal Disease Amongst Men on Furlough from Australian Auxiliary and British Hospitals', 30 March 1917, AWM: AWM15 14379/7. Punctuation has been altered for ease of reading.

⁸⁴ Major G Raffan, 'Incidence of Venereal Disease Amongst Men on Furlough from Australian Auxiliary and British Hospitals', 30 March 1917, AWM: AWM15 14379/7.

signs or symptoms), and advising those who had taken precautions that at the slightest indication of infection they should report to a Medical Officer with haste.⁸⁵

One of the most significant changes made by the AAMC to curb the effect of VD was an administrative one. On 27 March 1917, Colonel McWhae wrote to the Senior Medical Officers of Australian units in the UK regarding a new 'Weekly VD Return'. He wrote:

A weekly return as per sample attached is to be rendered by each RMO under your Administration and is to be dispatched on Fridays of each week. Each question is to be separately answered in detail and vague relies are not to be inserted.⁸⁶

The sample McWhae discussed eventually became AIF Form 587, pictured in Figure 5.1.⁸⁷ AIF Form 587 was also known as Army Medical Corps (AMC) Form 4 and on it the MO for each unit was required to record a range of factors including the number of soldiers who went on leave each week, the number who reported for prophylactic treatment, how many required abortive treatment, where they contracted the disease and whether each man had been inspected within 24 hours of his return to camp. MOs were also required to certify that they had given the monthly lecture on VD, had offered prophylactic kits to soldiers going on leave, the number accepted by soldiers and the number of condoms distributed.

⁸⁵ Major G Raffan, 'Incidence of Venereal Disease Amongst Men on Furlough from Australian Auxiliary and British Hospitals', 30 March 1917, AWM: AWM15 14379/7.

⁸⁶ Colonel DM McWhae to SMO Hurdcott, Codford, Lark Hill, No. 1, 2, 3, 4, Cmd Depots, Park House, 27 March 1917, AWM: AWM15 14379/7.

⁸⁷ 'Early Treatment and VD Report', AIF Form 587/AMC Form 4, AWM: AWM27 376/157 PART 2.

A.I.F. Form 587, -5,000-12/17-863 (A.M.C. (FORM 4.) 66)

EARLY TREATMENT AND V.D. REPORT.

For Week Ending 10 p.m. Thursday / /

UNIT..... AVERAGE RATION STRENGTH.....

No. OF V.D. EVACUATED TO HOSPITAL FOR WEEK.....

Where acquired (stating Towns and, where available, addresses)

Local..... London..... Elsewhere.....

.....

.....

.....

EARLY TREATMENT.

1. No. reporting for E.T.	Total Reported.	Washed Out.	Sealed Up.	Cured.
(A) With discharge ...				
(B) Without signs ...				
Totals ...				

MONTHLY LECTURE.

Has the Monthly Lecture been delivered?.....

WEEKLY EXAMINATION.

Has a short-arm parade of the whole Unit been held?.....

MEN GOING ON LEAVE.

1. Has a lecture been given to all men going on leave?.....
2. Have cards of advice been handed to each man?.....
3. Have Nargol Outfits been offered to each man?.....
4. Is there a supply of French Letters available?.....
5. No. of men who have gone on leave for the week.....
6. No. of cards of advice accepted for the week.....

No. of Preventives accepted. { French Letters.....
Nargol Outfits.....

MEN ARRIVING IN CAMP. WHETHER FROM SHORT LEAVE, 14 DAYS' FURLOUGH, OR FRESH DRAFT.

1. Has each man been examined as soon as possible after arrival?.....
2. All men coming into Camp must be strongly advised to attend the E.T. Dépôt if they have taken the risk without proper precautions.
Have you carried out this instruction?.....

To A.D.M.S. A.I.F.

R.M.O.
Unit.
S.M.O.
Date Date Despatched.

Figure 5.1: Example of AIF Form 587/AAMC Form 4

McWhae wrote to MOs who had particularly high rates of soldiers requiring abortive treatment or low rates of those accepting preventative or prophylactic treatment to question whether the MOs in question were adequately carrying out their responsibilities. To the Officer Commanding the AAMC Training Depot, Parkhouse, McWhae wrote: "Your attention is directed to the fact that the Early Treatment & Venereal Disease Returns for Parkhouse for the week ending 14th inst., are uniformly unsatisfactory."⁸⁸ As examples of unsatisfactory numbers McWhae included statistics from No. 1 Camp which had 73 men on leave during the week concerned with only four boxes of French Letters and 18 Nargol Outfits accepted and six soldiers evacuated to the VD hospital. No. 2 Camp only had two boxes of French Letters and eight Nargol Outfits accepted by the 45 soldiers going on leave. No men who returned from leave from No. 3 Camp were examined after their return and No. 4 Camp had no French Letters available. The Officer Commanding AAMC Training Depot was then asked to follow up on these observations. McWhae wrote:

Please carefully investigate personally the procedure adopted by the RMOs in each Camp in order to ensure that every man proceeding on any leave which necessitates the issuing of a leave pass is seen by the Medical Officer and advised regarding Early Treatment. Please also investigate the procedure by which he assures himself that all these men are again seen, examined and advised on their return from that leave. Please furnish a full report of the result of your investigation and steps taken by you to ensure satisfaction in future.⁸⁹

McWhae was not just interested in the number of preventative and prophylactic measures used, he also tried to ensure that lectures on VD happened in accordance with policy. He wrote to the OC AAMC Training Depot: "You state that the routine monthly lecture has not been delivered, and do not answer the final question concerning advice to men who have taken the risk without proper precautions. Please furnish a report."⁹⁰ Similar communications were sent by McWhae to the SMO, No. 1 Command Depot in June when for 187 men going on leave there were no French Letters available and only 20 Nargol Outfits were accepted. Thirty-seven men subsequently contracted VD after presumably

⁸⁸ Colonel DM McWhae ADMS AIF, Tidworth to OC AAMC Training Depot, Parkhouse, 16 June 1917, AWM: AWM15 14379/7.

⁸⁹ Colonel DM McWhae ADMS AIF, Tidworth to OC AAMC Training Depot, Parkhouse, 16 June 1917, AWM: AWM15 14379/7.

⁹⁰ Colonel DM McWhae ADMS AIF, Tidworth to OC AAMC Training Depot, Parkhouse, 23 April 1917, AWM: AWM15 14379/7.

using the prescribed abortive treatment. McWhae, somewhat ominously told the SMO that “Para. 1. Of Circular Instructions No. 37 will be adhered to strictly in future.”⁹¹ These are just a handful of examples of the communications that helped establish the new procedures within the culture of the medical service. In this McWhae became one of Raffan’s closest allies. The introduction of Form 4 to the required paperwork was not just a bureaucratic response to a cultural problem, it was a way of making the Medical Officer of a unit personally accountable for the rate of VD infection among his troops, thereby transferring a measure of the surveillance previously applied to soldiers to their Medical Officers. Should the MO’s efforts not be deemed to be satisfactory he was required to justify the work done. Thus, MOs were required to institute the VD policies and procedures of the AAMC in their units irrespective of whether or not they agreed with doing so.

The “well-toileted penis”: Instructions to Medical Officers

Further contributing to 1917 as the landmark year in the prevention of the venereal contagions was Major Raffan’s distribution of instructions for Medical Officers on the treatment of venereal disease on 10 February 1917.⁹² These instructions concerned information about the Medical Officers’ responsibilities, education of soldiers about VD and its effects, precautionary measures that should be adopted, the curiously named ‘short-arm parades’, and the disposal of VD cases. These instructions were revised over the remainder of the war and are here compared to those issued on 16 September 1918 in order to highlight the changes made to the instructions.⁹³ In the February 1917 instructions Raffan outlined the idea underpinning the program, writing: “Every irregular sexual intercourse must be regarded as a probable source of infection.”⁹⁴ He then attempted to get the non-medical hierarchy to support the work of the medical corps in limiting the effects of VD. Raffan wrote: “All Officers must be duly instructed, and their cooperation sought in imparting certain broad facts regarding venereal disease, particularly as to the dangers run and the methods they should adopt to avoid disease.”⁹⁵ This directive changed between February 1917 and September 1918. By the latter date MOs had been using Form 4 for

⁹¹ Colonel DM McWhae ADMS AIF, Tidworth to SMO No. 1 Command Depot, Parham Down, 16 June 1917, AWM: AWM15 14379/7.

⁹² Major G Raffan, ‘Instructions to Medical Officers’, 10 February 1917, AWM: AWM27 376/193.

⁹³ Lieutenant Colonel G Raffan, ‘Instructions to Medical Officers Regarding the Prevention of Venereal Disease’, 16 September 1918, AWM: AWM27 376/157 PART 2.

⁹⁴ Major G Raffan, ‘Instructions to Medical Officers’, 10 February 1917, AWM: AWM27 376/193.

⁹⁵ Major G Raffan, ‘Instructions to Medical Officers’, 10 February 1917, AWM: AWM27 376/193.

months to report the number of soldiers accessing various preventative and prophylactic methods and treatments. In September 1918 it was made clear to the MOs that they were responsible for the rate of VD infection within their units. Raffan, who in September 1917 had been promoted to Lieutenant Colonel,⁹⁶ told them: “The success or failure of the campaign depends mainly upon the zeal and efficiency of the MO and the spirit in which he carries out instructions, comprised in the Return AIF Form 587. A mere perfunctory discharge of duty and filling up of forms will not suffice.”⁹⁷ The contrast between these statements, made around 18 months apart, indicate the shift that occurred in the thinking around VD and demonstrates the change to this becoming a largely medical concern. Military hierarchies and authorities took a secondary role, only to be used if necessary to reinforce the medical message.

The second issue discussed by Major Raffan in the February 1917 instructions was that of “precautionary methods to be adopted”, which was discussed in three parts: French Letters, Nargol Outfits and Early Treatment. Regarding French Letters Raffan wrote:

THE FRENCH LETTERS ARE THE ONLY COMPARATIVELY SAFE MEANS OF PREVENTING DISEASE. Those men who are accustomed to take the risk should be strongly advised to use French Letters. To make the procedure safer still, calomel ointment should be applied to the scrotum and skin surface adjoining the root of the penis.⁹⁸

Raffan also suggested that each Medical Officer attempt to get the Commanding Officer of their unit to ensure a supply of French Letters was kept in the unit stores for men to purchase before going on leave. They cost two shillings each (around a third of a private’s daily pay) and were also available at the Early Treatment Depot in Room 100A at 130 Horseferry Road, London, the Australian Headquarters.⁹⁹ Lieutenant Colonel Raffan’s September 1918 instructions regarding French Letters did not differ substantially from the earlier ones, except that the responsibility for procurement shifted to the MO. Raffan

⁹⁶ George Raffan, NAA: B2455 RAFFAN GEORGE/8023997.

⁹⁷ Lieutenant Colonel G Raffan, ‘Instructions to Medical Officers Regarding the Prevention of Venereal Disease’, 16 September 1918, AWM: AWM27 376/157 PART 2.

⁹⁸ Major G Raffan, ‘Instructions to Medical Officers’, 10 February 1917, AWM: AWM27 376/193. Emphasis in original.

⁹⁹ Major G Raffan, ‘Instructions to Medical Officers’, 10 February 1917, AWM: AWM27 376/193.

wrote: "Take care always to have an adequate supply on hand."¹⁰⁰ This, once again, shifted the responsibility to the MO rather than the Commanding Officer of the unit.

Nargol Outfits, which included one tube of calomel ointment and one tube of Nargol jelly, were to be handed out every man going on leave and the way to use them explained. Before sexual intercourse the soldier was supposed to smear his entire penis (glans, shaft, root, as well as scrotum and surrounding skin) with the calomel ointment as well as squeezing some into the meatus. After sex, soldiers were instructed to urinate then wash thoroughly in soap and water and Lysol, if it was available. Half the Nargol was then to be inserted into the meatus within two hours, preferably 30 minutes, of the act. Finally, the penis was again to be smeared in calomel ointment.¹⁰¹ By September 1918 the use of Nargol Outfits had been discontinued and in their place was the 'Blue Label Outfit', which contained tablets of potassium permanganate, cotton wool, a two-ounce bottle, three tubes of ointment and instructions. The ointment was a mix of calomel, camphor, carbolic acid, lanolin, and paraffin. This self-treatment kit was to be used by the soldier both immediately before and after 'connection' and detailed instructions were part of the monthly lectures to be delivered to soldiers.¹⁰²

Medical Officers were advised in early 1917 to instruct soldiers who had sex to report to the Early Treatment Depot at the Australian Headquarters at Horseferry Road, even if the soldier had used a Nargol Outfit. Raffan urged the MOs to impress upon the soldiers the importance of haste in preventing infection. He wrote:

The Depot in London is never shut. There is always a man on duty day and night to attend to applicants. A shilling or two spent on a taxi to get attention the same evening would be very well spent. Early treatment at the London Depot lasting a few minutes is preferable to late treatment at the Bulford Venereal Hospital lasting a few weeks, or even months.¹⁰³

The instructions issued in September 1918 gave more information to Medical Officers and subsequently soldiers regarding why prompt treatment was so important. Especially in the case of syphilis it was thought that applying early treatment may be useless if the soldier

¹⁰⁰ Lieutenant Colonel G Raffan, 'Instructions to Medical Officers Regarding the Prevention of Venereal Disease', 16 September 1918, AWM: AWM27 376/157 PART 2.

¹⁰¹ Major G Raffan, 'Instructions to Medical Officers', 10 February 1917, AWM: AWM27 376/193.

¹⁰² Lieutenant Colonel G Raffan, 'Instructions to Medical Officers Regarding the Prevention of Venereal Disease', 16 September 1918, AWM: AWM27 376/157 PART 2.

¹⁰³ Major G Raffan, 'Instructions to Medical Officers', 10 February 1917, AWM: AWM27 376/193.

waited more than one hour from incurring the risk of infection. For gonorrhoea and chancroid, attendance at a 'Blue Light Depot' within 12 hours of connection virtually guaranteed the soldier would remain healthy and that was still highly likely if early treatment was sought between 12 and 24 hours. After that point Raffan suggested that the best course of action to prevent gonorrhoea and chancroid would be to commence with the first day's treatment of the abortive treatment.¹⁰⁴

The early treatment provided at the 'Blue Light Depot' was invasive and unpleasant, though it was relatively quick, only taking around thirty minutes to administer. The first step was to get the soldier to urinate and if there was any discharge present this was collected on a slide and examined through a microscope. The penis and scrotum were then washed thoroughly in soap and water before being washed in a 1:2000 solution of bichloride, biniodide or mercury. After this, a small, thin wooden applicator (some versions of the same instructions suggest using a match) was wrapped in cotton wool and dipped into a 10% protosil solution and inserted into the urethra for about half an inch and held there for three minutes. Previous treatments involved injecting the solution via a syringe but that prevented some of the skin from coming into contact with the solution as it was instead in contact with the needle. Once this has been done an Orderly was to inject one drachm of 10% protosil (or Argyrol if available) solution that was held inside the penis for five minutes. A 30% calomel ointment was then rubbed over the entire organ skin, around the root, frenum and prepuce for at least five minutes before it was wrapped in clean strips of linen. Raffan argued that this method was far more useful than the previously sanctioned irrigation method, could be performed by an orderly, and it was more effective in all cases reporting more than 12 hours after connection. Raffan also pointed out that as many men were under the influence of alcohol when they had sex, and they were encouraged to seek medical assistance as soon as possible afterwards, many were still drunk when they arrived at the 'Blue Light Depot'. He wrote "It is not an easy thing for a man half intoxicated to irrigate himself with a bucket syphon apparatus."¹⁰⁵

The abortive early treatment method in early 1917 followed similar principles to the early treatment method; however, from September 1918 onward was far more invasive and involved. It lasted seven days and on day eight the soldier was either discharged to the lines

¹⁰⁴ Lieutenant Colonel G Raffan, 'Instructions to Medical Officers Regarding the Prevention of Venereal Disease', 16 September 1918, AWM: AWM27 376/157 PART 2.

¹⁰⁵ Lieutenant Colonel G Raffan, 'Instructions to Medical Officers Regarding the Prevention of Venereal Disease', 16 September 1918, AWM: AWM27 376/157 PART 2.

as cured, or if he was not cured, he was evacuated to the venereal hospital. The treatment was effective and Raffan wrote: "It should be a regular result to cure at least 80% of all cases reporting for the Abortive Treatment. Anything below this standard shows that something is wrong, either in the organization or with the method of carrying out the treatment."¹⁰⁶ The method used was the result of the experience of the previous four years and was tailored to the supplies available to the Medical Officers through the existing medical stores and chains of supply. Raffan wrote:

Experience has demonstrated that the 'Massage-Plug' method is the best, and it will therefore be adopted to the exclusion of all other existing methods. Any Medical Officer who desires to try a new method, or to modify the existing method in any particular, must receive the written authority of the DMS AIF, through the ADMS, AIF Tidworth, or the ADMS Division, before instituting any such method.¹⁰⁷

Raffan's September 1918 instructions also gave Medical Officers guidance on the apparatus to use based on the individual differences of the soldiers. There were two different methods for probing the penis based on its size. The preferred method was to insert a large probe into the urethra "to determine its general direction and whether there is any narrowing or other obstruction", before inserting, with a twirling rotary motion and whilst massaging the penis, another smaller probe dressed in cotton wool dipped in a 5% Argyrol solution.¹⁰⁸ It needed to go roughly 2.5 – 3 inches into the urethra, but at least 1 inch beyond the tender area. The probe was then extracted by rotating it in the opposite direction leaving the cotton wool inside the urethra as a plug. For a small meatus the cotton wool strip was rolled up, dipped in the same Argyrol solution and pushed into place using a "moderately large" probe.¹⁰⁹

Accordingly the individual initiative used previously by Medical Officers in their individual efforts against VD was not completely stamped out but curtailed and placed within the medical-military hierarchy rather than being instituted on a Divisional or Corps

¹⁰⁶ Lieutenant Colonel G Raffan, 'Instructions to Medical Officers Regarding the Prevention of Venereal Disease', 16 September 1918, AWM: AWM27 376/157 PART 2.

¹⁰⁷ Lieutenant Colonel G Raffan, 'Instructions to Medical Officers Regarding the Prevention of Venereal Disease', 16 September 1918, AWM: AWM27 376/157 PART 2.

¹⁰⁸ Lieutenant Colonel G Raffan, 'Instructions to Medical Officers Regarding the Prevention of Venereal Disease', 16 September 1918, AWM: AWM27 376/157 PART 2.

¹⁰⁹ Lieutenant Colonel G Raffan, 'Instructions to Medical Officers Regarding the Prevention of Venereal Disease', 16 September 1918, AWM: AWM27 376/157 PART 2.

basis. This systematisation of process was echoed in the systematisation of the supplies used. Given the number of men across combatant armies in Europe who were infected with VD it is unsurprising that there were shortages of particular supplies. Raffan was aware of this and altered the instructions to Medical Officers accordingly: "Argyrol has proved the most suitable; failing Argyrol, the next best is Protosil. Silver Nucleinate, though efficient, is more irritating, and is not recommended."¹¹⁰ Argyrol was in short supply during the war as it was the most effective solution in the treatment of VD.¹¹¹

The introduction of 'short-arm parades' created a routine for the inspection of men's bodies. In these parades soldiers presented their genitals for inspection by the Medical Officer. In February 1917 Raffan instructed that they should be held once a week and immediately after men return from leave or arrive in camp for the first time. He also suggested they were important to both prevent VD and ensure the cleanliness of the foreskin. Regarding how they should be conducted, Raffan wrote:

Short-arm Parades must be absolutely strict. No man should be allowed to escape them. If men know that their venereal disease is bound to be discovered sooner or later they will be induced to report early. The ideal system is for Medical Officers to gain the confidence of the men with regard to early reporting of suspected disease.¹¹²

This surveillance of the male body was intended to encourage men to report as early as possible for treatment. By September 1918 the process of inspection through short-arm parades became more systematized. Raffan told MOs that: "These parades must be conducted under the control of a nominal roll. They tend to discourage concealment of disease, and very often a small sore is found which the many may regard as of no importance."¹¹³ This was a way of ensuring that minor problems did not turn into intractable diseases thereby decreasing the efficacy of any future treatments. In the British and New Zealand armies these inspections were termed "dangle parades" and in the British army a soldier could be asked at any time by an officer or NCO to drop his pants and

¹¹⁰ Lieutenant Colonel G Raffan, 'Instructions to Medical Officers Regarding the Prevention of Venereal Disease', 16 September 1918, AWM: AWM27 376/157 PART 2.

¹¹¹ Lieutenant Colonel G Raffan, 'Instructions to Medical Officers Regarding the Prevention of Venereal Disease', 16 September 1918, AWM: AWM27 376/157 PART 2.

¹¹² Major G Raffan, 'Instructions to Medical Officers', 10 February 1917, AWM: AWM27 376/193.

¹¹³ Lieutenant Colonel G Raffan, 'Instructions to Medical Officers Regarding the Prevention of Venereal Disease', 16 September 1918, AWM: AWM27 376/157 PART 2.

present for a dangle parade, including in public areas of a camp.¹¹⁴ In contrast, the AAMC's MOs were routinely reminded that this could be a cause for embarrassment for a soldier and that short-arm parades should only be conducted one-on-one in a curtained-off area of a medical tent in order to further engender trust between the soldier and the Medical Officer. Raffan was aware of this issue and told MOs "Such examinations should be strictly private. It is unpleasant for men to be examined publicly, so let men come in to you singly. It is easy to shut off a portion of a hut, if not already done."¹¹⁵ These parades were systematic and ensured that men were paying adequate attention to hygiene as "a well-toileted penis is less likely to become abraded than one under whose foreskin smedma and debris are allowed to gather and irritate the mucous membrane."¹¹⁶ These weekly parades were the strongest indicator of the willingness of the AAMC to surveil and attempt to control the bodies of the men it served.

"For the sake of Australia's womanhood": Lecturing Australian Soldiers

By 1917 all members of the AIF in the UK were supposed to have monthly lectures on the prevention, consequences, and early treatment of venereal disease, and each base had to report back to headquarters to acknowledge whether or not this lecture had taken place. The lectures demonstrate the thinking behind the strategies implemented in the fight against venereal disease and covered a range of issues that influenced soldiers' decision making with regard to their sexual health. The model lecture was included as an appendix in the instructions to Medical Officers in both early 1917 and September 1918 and was supposed to be delivered to every unit in Britain each month. The actual wording to be used was at the discretion of the individual Medical Officer but it was to contain the content outlined by Raffan in the sample.

The sample lecture from February 1917 began with statements about the broad problem that VD posed to the efficiency of the army and the honour of Australia. Raffan instructed the MOs to remind soldiers that abstinence from sex was not harmful to them and attempted to invoke their national pride. The sample lecture stated:

¹¹⁴ Harrison, *The Medical War*, 155; Kampf, "Controlling Male Sexuality," 236.

¹¹⁵ Lieutenant Colonel G Raffan, 'Instructions to Medical Officers Regarding the Prevention of Venereal Disease', 16 September 1918, AWM: AWM27 376/157 PART 2.

¹¹⁶ Lieutenant Colonel G Raffan, 'Instructions to Medical Officers Regarding the Prevention of Venereal Disease', 16 September 1918, AWM: AWM27 376/157 PART 2.

The honour of Australia lies in the hands of the men who left their homes to serve her. It is a serious responsibility, and every man who is worthy will endeavor to keep a clean record, so that at the end of the war we shall be able to proudly state that the percentage of venereal disease cases in the Australian Army was remarkably low. Think of the national disgrace if the opposite results, and we have to state that the percentage of venereal disease was regrettably high.¹¹⁷

This statement made a soldier's VD record an indicator of his national pride and devotion to duty. MOs were then to inform soldiers that every 'unprotected connection' needed to be thought of as a likely source of infection, especially in the case of amateurs. The preventive measures available to soldiers were then outlined in detail before the MO was to articulate the problems with concealing disease from the medical staff. Soldiers were to be told:

The man who conceals his disease will get it firmly established in his system and it may be months – even years – before he is cured. Take advantage of these opportunities to keep fit. Play the game fairly and the loss to the fighting strength from preventable disease will be considerably reduced.¹¹⁸

This lecture framed the manpower economy of the AIF as the personal responsibility of each soldier. Not only did VD have serious, and potentially long-term, consequences for the individual soldier's health, it was also then within his power to bolster the AIF's fighting strength.

The lecture from September 1918 covers much the same territory as the early 1917 version. It commenced with a discussion of the idea of sexual continence and argued against the ideas that continence was damaging or harmful to a man's health and that incontinence was a demonstration of 'manliness'. Referred to already in this chapter, these ideas were prevalent in Australian society, as well as in British and other societies. Unlike in late twentieth century sexual-health campaigns the soldiers were not given instruction in other methods of sexual activity such as masturbation.¹¹⁹ Lisa Featherstone found that masturbation was generally considered to be a threat to the army; she argues it was

¹¹⁷ Major G Raffan, 'Lecture to be Delivered by RMOs Concerning the Prevention of Venereal Disease', 10 February 1917, AWM: AWM27 376/193.

¹¹⁸ Major G Raffan, 'Lecture to be Delivered by RMOs Concerning the Prevention of Venereal Disease', 10 February 1917, AWM: AWM27 376/193.

¹¹⁹ Paul Sendziuk, *Learning to Trust: Australian Responses to AIDS* (Sydney: UNSW Press, 2003), 27.

considered able to “render men unfit for military service and procreation which were vital to contemporary ideals of masculine citizenship”.¹²⁰ She also found that “the male body was therefore envisioned as a body to be disciplined”.¹²¹ The idea that a woman was a necessary part of this equation is supported by the suggestion that masturbation was considered to result in the withering of a man’s virility. By this reasoning, man derived his virility and masculinity from congress with women. The lectures by the Medical Officers were not the first time this idea was presented to the soldiers. It was one that the Medical Officers adopted from the purity movements in Britain. Their pamphlets on ‘True Manliness’ discuss the importance of abstinence as an act of self-discipline encouraging men to “[hold] fast to those things which are certain still, the grand, simple landmarks of morality”.¹²² They were to do this in order to “hand down an unbroken constitution to [their] children, and those high traditions which will make them in their turn the pure sons and daughters of a pure father”.¹²³

In the September 1918 lecture, the discussion of continence was followed by an analysis of the effects of alcohol on the rate of infection. The number of soldiers who reported having been under the effects of alcohol when they incurred the risk of infection led the Medical Officers to believe that they could reduce the rate of infection by reducing the consumption of alcohol.¹²⁴ It was also far more difficult to self-administer prophylactic treatment while intoxicated. Medical Officers believed that the soldiers were not administering the process effectively resulting in a higher than expected VD rate for those who had attempted prophylactic treatment. This idea of the link between alcohol and VD was also explored by British purity organisations with the Medical Officers using the same argument as the moralists but with a more pragmatic bent.¹²⁵

In the lecture, the diseases themselves were then discussed, providing soldiers with information about the symptoms, complications and the effects they may have on any

¹²⁰ Featherstone, *Let’s Talk about Sex*, 49.

¹²¹ Featherstone, *Let’s Talk about Sex*, 50.

¹²² White Cross League, *True Manliness* (Westminster: White Cross League, 1913), 31, Wellcome Library (hereafter WL): SA/BSH/L.4.

¹²³ White Cross League, *True Manliness*, 32, WL: SA/BSH/L.4.

¹²⁴ Lieutenant Colonel G Raffan, ‘Lecture to be Delivered by Medical Officers Concerning the Prevention of Venereal Disease’, 16 September 1918, AWM: AWM27 376/157 PART 2.

¹²⁵ The National Council for Combating Venereal Diseases (hereafter NCCVD), *The Speakers’ Handbook: Compiled for the Use of Lecturers Representing the National Council for Combating Venereal Diseases* (London: NCCVD, 1917) 18, WL: SA/BSH/L.1.

future offspring. This was done in some detail with Medical Officers asked to inform soldiers of the damaging effects of VD and not withhold graphic descriptions of the diseases, the discomfort of the symptoms, and the effects on their future wives and children. Here the Medical Officers differed somewhat from the purity movements in their approach to passing on medical information. Both groups attempted to change soldiers' behaviour through a discussion of the complications for the wives and children of the soldiers.¹²⁶ The Medical Officers were asked to outline for the soldiers the medical consequences on the 'innocent' victims of the diseases. They were given a straightforward assessment of the potential for pain, miscarriage, death, and illness. In contrast the purity movement, exemplified by the White Cross League, issued pamphlets attempting to harness the masculine honour of the soldier as the protector of woman and cast him as a potential hero.¹²⁷ The AAMC also provided information to soldiers about the consequences of contracting VD on their own health whereas the White Cross League simply cast infected soldiers as delinquent and guilty rather than giving any information about the disease.

After this description of the disease, the soldiers were then informed of the need for prophylaxis and early treatment, and the problems posed by concealing the disease from their Medical Officer or using remedies from an unsanctioned source. Soldiers were told that if prophylactic treatment was sought, and administered properly, the risk of infection was extremely low. They were also given statistics on the efficacy of the abortive treatment. They were informed that if they presented for the abortive treatment method, and it was too many hours after connection for the prophylactic treatment to be effective, they could still be cured of VD in 80 per cent of cases. This is where the attempts by the AAMC and the purity movements to prevent VD diverged markedly. The purity movements viewed the presentation of anything other than sexual continence as the promotion of vice so did not advocate for the use of prophylactics and actively worked against the implementation of a similar system for the British army.¹²⁸

The methods of prophylaxis and early treatment used at Blue Light Depots were then outlined for soldiers. This was done so that soldiers knew what to expect from the treatment and it was made clear to them that the longer they left seeking treatment, the

¹²⁶ NCCVD, *The Deadly Peril of Venereal Diseases* (London: NCCVD, 1917) 5, WL: SA/BSH/L.1.

¹²⁷ White Cross League, *A Paper for Men* (Westminster: White Cross League) 7, WL SA/BSH/L.4.

¹²⁸ Harrison, *The Medical War*, 169.

more invasive and protracted the treatment was. The preventive measures at their disposal took five minutes, the prophylactic treatment, if administered within 24 hours of connection, took around thirty minutes and the abortive treatment consisted of multiple treatments each day for a week. All of these were portrayed as preferable to needing to be hospitalised for an average of 53 days with regular treatments.¹²⁹ Some parts of the army were concerned that the extended stay in hospital would be attractive to potential shirkers and wasters.¹³⁰ Viewing VD as a self-inflicted wound ensured that punitive consequences would be continued for those who were admitted to hospital.¹³¹

The lecture was designed to end with an invocation to remain healthy for the sake of both military efficiency and the benefit of their country and Empire. Soldiers were told:

At this critical period, the Empire can ill afford to lose a man from disease that is preventable. For the sake of Australia's womanhood and the welfare and happiness of the Commonwealth, keep your bodies and minds pure, for venereal disease is the great destroyer of national and individual happiness.¹³²

The issue of VD was therefore framed in terms of national and imperial fidelity as well as one of masculine pride. This supports Featherstone's argument, mentioned earlier, that the discourse about sex was rarely about pleasure. The pleasure of sex is not mentioned once in the lectures; presumably the soldiers did not need to be convinced of this aspect. It was, however, framed in terms of patriotism, gender roles, and health.

It is impossible to determine whether the lectures were effective in slowing the rate of disease because they were instituted at the same time and in conjunction with a range of other measures. What is significant is the way that the problem of VD was framed and presented to the soldiers and how it differed from other messages regarding sexual health that were circulated at the time. Whilst there were similarities in the approaches taken by the AAMC and the purity movements, such as the White Cross League and the National Committee for the Prevention of Venereal Disease, there were distinct differences. Both were trying to achieve the same goal – that of a reduction in the rate of venereal disease among soldiers. The purity movements attempted to do this by appealing to the soldier's

¹²⁹ Lieutenant Colonel G Raffan, 'Lecture to be Delivered by Medical Officers Concerning the Prevention of Venereal Disease', 16 September 1918, AWM: AWM27 376/157 PART 2.

¹³⁰ Harrison, *The Medical War*, 158.

¹³¹ Blackmore, *The Dark Pocket of Time*, 145.

¹³² Lieutenant Colonel G Raffan, 'Lecture to be Delivered by Medical Officers Concerning the Prevention of Venereal Disease', 16 September 1918, AWM: AWM27 376/157 PART 2.

sense of male pride and invoking the image of the protector. The AAMC, in contrast, attempted to present evidence based on the medical understanding of the time and promote a proactive approach to sexual health that acknowledged the reality that soldiers were willing to risk infection.

The Efficacy of Raffan's Approach to Venereal Disease

Lieutenant Colonel Raffan wrote yet another report in 1918 outlining why treatment methods had worked and pinpointing the turning point in the prevention of disease. He stated that after Form 4 was added to the required paperwork of units and bases the attempts to combat VD became more successful.¹³³ Raffan's statistics show that the rate of infection from VD decreased significantly over the course of the war. From the initial ten per cent of the relatively small contingent that initially landed in Egypt, a number that some analyses have suggested should be doubled,¹³⁴ the rate for the AIF Depots in the UK decreased to 3.7% in 1917 and further down to 2.34% of men in 1918.¹³⁵ These rates include men from sections of the army who were not counted on the strength of the units in question (members of the Australian Flying Corps or those soldiers on leave from France) thereby inflating the percentage of men from AIF Depots in the UK who had contracted VD. When these factors are allowed for the rate of infection works out to just under two per cent of the force.

The weekly returns that were sent to headquarters on Form 4 in order to monitor the problem of venereal disease show that soldiers were willing to take the advice of the Medical Officers and proactively manage their sexual health. The number of advice cards accepted by soldiers was high with Nargol Outfits also routinely accepted by soldiers. As a general rule fewer condoms than Nargol Outfits were taken by soldiers before they went on leave. This was to be expected as condoms cost soldiers between two and three shillings each whereas Nargol Outfits were free of charge to soldiers going on leave. The most startling information to be gleaned from the Form 4 statistics is the high rate of soldiers reporting for early treatment after returning from leave. Those statistics were compiled for the period 2 May 1918 to 2 January 1919 and, as can be seen in Figure 5.2, when the units

¹³³ Lieutenant Colonel G Raffan, 'Table Showing the Percentage of Venereal Disease from 18/1/17 until 7/3/18', AWM: AWM27 376/157 PART2.

¹³⁴ Stanley, *Bad Characters*.

¹³⁵ Lieutenant Colonel G Raffan, 'Table Showing the Percentage of Venereal Disease from 18/1/17 until 7/3/18', AWM: AWM27 376/157 PART2.

that comprised the AIF in the UK are considered together, the proportion of soldiers going on leave each week who returned and sought prophylactic, or early, treatment rarely dropped below sixty per cent. Over the same period, around forty per cent of soldiers purchased French Letters from their MO, and almost double that number accepted Blue Label Outfits. The number of soldiers requiring abortive treatment is also consistently low.

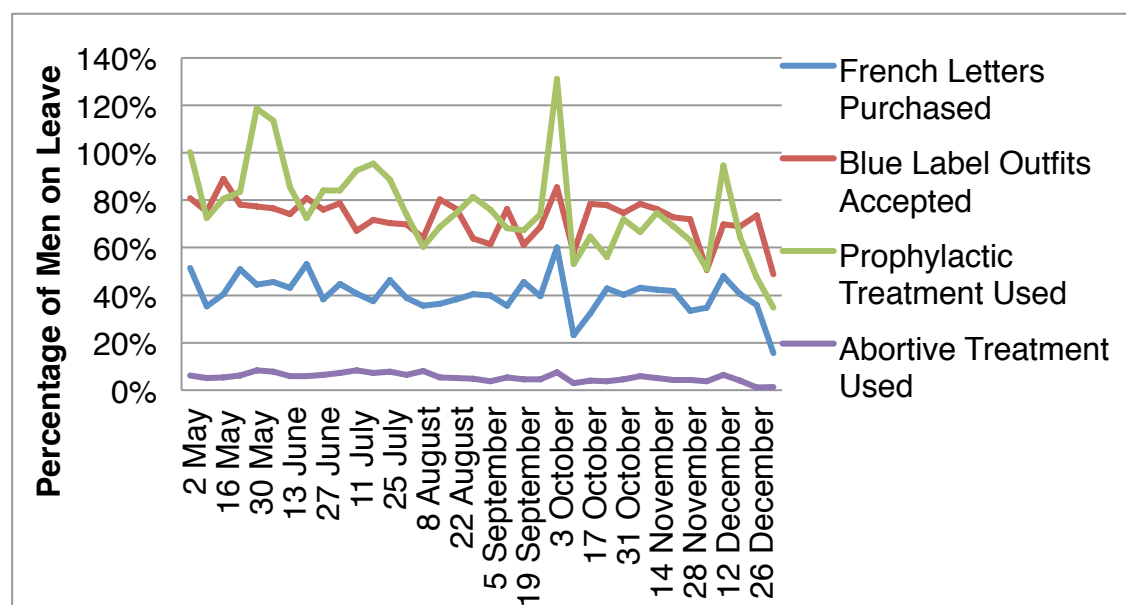


Figure 5.2: Methods Used by Men on Leave in 1918 (AIF in UK)¹³⁶

These statistics, especially for the percentage of men accepting Blue Label Outfits and purchasing French Letters, are most likely inflated as some men would have taken more than one of each. They are also crude measures as they assume that the number of men going on leave was roughly equivalent to the number returning. This does not account for the different lengths of leave or battlefield developments that require the recall of large numbers from leave simultaneously. When read together, however, these statistics suggest that the Australian soldiers did heed the message from Lieutenant Colonel Raffan, through their Regimental Medical Officers, that they were able to take personal responsibility for their sexual health. Unlike in the British Army, where Joanna Bourke found that the majority of British soldiers did not have ‘irregular’ sex over the course of the First World War, the Form 4 statistics suggest that the majority of Australian soldiers did engage in casual sex, whether that was with prostitutes or amateurs.¹³⁷

¹³⁶ Compiled from ‘Consolidated Prophylactic and Early Treatment Venereal Reports’, AWM: AWM27 376/189.

¹³⁷ Joanna Bourke, *Dismembering the Male: Men’s Bodies, Britain and the Great War* (London: Reaktion Books, 1996), 156.

A further measure of the success of Raffan's VD prevention policies is the rate at which members of the AIF were admitted to the venereal disease hospital, 1ADH Bulford. As shown in Figure 5.3, the proportion of those on leave each week who were sent to Bulford fluctuated wildly (for the same reasons mentioned above); however, when measured against the strength of the AIF in the UK, which averaged 27,283 during the period in question, the Bulford admissions average 0.28 per cent of the force and do not exceed 0.4 per cent. This was a substantial reduction in the rate of VD in the AIF from the beginning of the war, and the provision of abortive treatment in soldiers' units prevented many men being unnecessarily evacuated to Bulford.

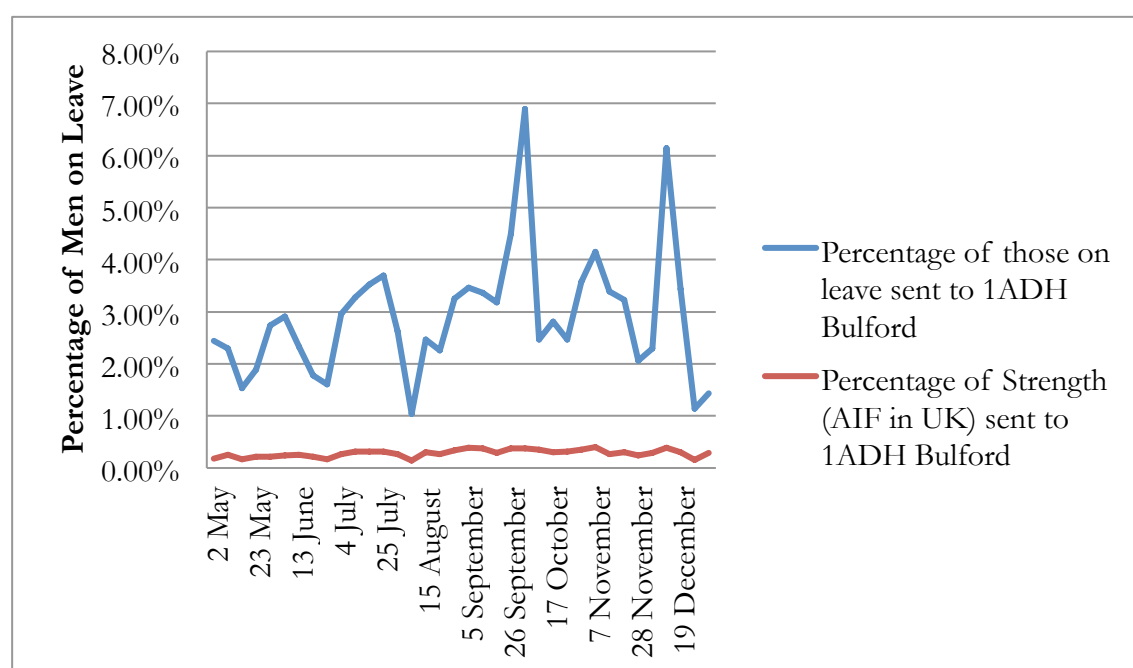


Figure 5.3: Percentage of AIF in UK Admitted to 1ADH Bulford in 1918¹³⁸

Responding to Venereal Disease in the Lines

Given that the vast majority of the AIF's VD cases were contracted in London, while soldiers were on leave, the AAMC concentrated its efforts to combat the impact of VD on the efficiency of the AIF in the UK. However, the AAMC did not ignore the possibility that symptoms may become evident, or soldiers could become infected, whilst in reserve areas or in the trenches in France and Flanders. As mentioned in Chapter 3, Colonel Manifold, Deputy Director of Medical Services (DDMS) for the Australian Corps, attended a conference at the headquarters of the Fourth Army for all DDsMS and Assistant

¹³⁸ Compiled from 'Consolidated Prophylactic and Early Treatment Venereal Reports', AWM: AWM27 376/189.

Directors of Medical Services (ADsMS) in that Army, of which the Australian Corps and its five constituent Australian Divisions were a part. Manifold wrote: “Venereal was discussed. It was found that we were the only Corps which had regimental arrangements for preventive treatment for men returning from large towns and also arrangements for this in towns near the troops.”¹³⁹ Taking an active role in the prevention of VD in the AIF, Manifold visited treatment centres in Paris. He recorded in his war diary:

Prophylactic treatment centres for Venereal in Paris established by the A[ssistant] P[rovost] M[arshal] for the benefit [sic] of men on leave were visited, and I was much struck by the fact that the Canadian YMCA had furnished [sic] accommodation in one of their huts for a prophylactic centre run on the same principle as the blue light room. Need for funds to buy drugs was urgent as the government does not supply drugs or funds.¹⁴⁰

The Canadian Corps was also part of the Fourth Army alongside the Australian Corps at this point in the war. If the Australians were ‘the only Corps’ with preventative treatment available once men returned to their units from leave, it suggests that, unlike in the Australian case, the Canadian approach to VD taken behind the lines had not translated to combat units as well. Subsequent to this visit Manifold recorded that he “Wrote to General Howse relative to the treatment centres in Paris and the need of support for them.”¹⁴¹ Not content to cease his advocacy after he had exhausted the medical chain of command, Manifold also took up the problem with General Birdwood, the Officer Commanding the Australian Corps. The day after he wrote to Howse, Manifold recorded in his war diary: “Spoke to [Army Corps Commander] about arrangements in Paris for prophylaxis. He said he had asked General Howse to visit Paris with a view to the AIF taking a proper share in the work.”¹⁴²

In response to what he had discovered in Paris Colonel Manifold gathered together his ADsMS in the Australian Corps to discuss VD prophylaxis. He reported:

¹³⁹ Colonel CC Manifold, War Diary 18 February 1918, DDMS Australian Corps – February 1918, AWM: AWM4 26/17/2.

¹⁴⁰ Colonel CC Manifold, War Diary 9 March 1918, DDMS Australian Corps – March 1918, AWM: AWM4 26/17/3.

¹⁴¹ Colonel CC Manifold, War Diary 12 March 1918, DDMS Australian Corps – March 1918, AWM: AWM4 26/17/3.

¹⁴² Colonel CC Manifold, War Diary 13 March 1918, DDMS Australian Corps – March 1918, AWM: AWM4 26/17/3.

All were agreed that at present the men were not acquiring venereal in the support and reserve areas such as Bailleul, Locre and that the Battalion Blue Light Treatment rooms quite sufficed. In Boulogne and St. Omer the 1st and 2nd Aust. Divisions had already taken the necessary steps. The importance of inspections of men returning from leave was agreed to. Also that information to those going on leave should be given as to where treatment was obtainable in large centres they were proceeding to such as Paris.¹⁴³

Vigilance was required by Medical Officers in providing information to soldiers going on leave and inspecting soldiers upon their return. Here the responsibility for VD was placed on the Medical Officer. When passing on the decision of the ADsMS to the Commanding Officers of the Field Ambulances and the Regimental Medical Officers (RMO) in the 1st Australian Division, Colonel Huxtable, ADMS of the Division, wrote:

The incidence of this disease continues to show a large number of cases in the Division, mostly contracted by men on leave in LONDON, EDINBURGH AND PARIS, in that order. These are probably cases arising from neglect of prophylaxis [*izi*], and as centres for these measures exist in all large cities, further efforts must be made to ensure all men going on leave are informed of the danger of the neglect of prophylaxis.¹⁴⁴

With the problem viewed as one of awareness rather than one of resistance to prophylaxis, responsibility for lowering the rate of infection was shared between the medical services and the soldiers. RMOs were to see men going on leave and instruct them on the “risks of promiscuous intercourse”, the necessity of prophylaxis every time the “risk has been run”, and then, when in the vicinity of a large town, establish their own prophylaxis station and encourage men to use it, irrespective of whether one already existed in the town.¹⁴⁵ RMOs were able to order French Letters, to sell at cost to soldiers, from Headquarters when the order was countersigned by the ADMS and from 21 May 1918 onward Nargol Outfits were available on order from the 1st Australian Field Ambulance. They were free to distribute to soldiers going on leave though they had to be ordered only for imminent use

¹⁴³ Colonel CC Manifold, War Diary 13 March 1918, DDMS Australian Corps – March 1918, AWM: AWM4 26/17/3.

¹⁴⁴ Colonel RB Huxtable, ‘Venereal Disease’, 16 March 1918, War Diary Appendix 13, ADMS 1st Aust. Div. – March 1918, AWM: AWM4 26/18/40.

¹⁴⁵ Colonel RB Huxtable, ‘Venereal Disease’, 16 March 1918, War Diary Appendix 13, ADMS 1st Aust. Div. – March 1918, AWM: AWM4 26/18/40.

as the Nargol eroded the tubes in which it was stored if they were kept for too long.¹⁴⁶ Once this information had been provided by the medical services it was then the soldiers' responsibility to use that knowledge to avoid infection. The inspection regime implemented behind the lines through the use of short-arm parades was, however, continued in forward areas with men required to visit their RMO for the same purpose. Colonel Huxtable wrote:

All men returning from leave must be made to report to RMO, who should inspect with a view to making sure that no venereal disease has been contracted whilst on leave, and obtaining the earliest possible treatment where such has occurred.¹⁴⁷

With these refinements for those going on and returning from leave put in place, the AAMC also created procedures for dealing with cases of VD in forward areas. Venereal cases were expressly prohibited from treatment in forward medical units requiring them to be immediately evacuated to either the 'Special Centre' that was part of the 2nd Australian Casualty Clearing Station or the one at the New Zealand Stationary Hospital, depending on the location of the soldier's unit.¹⁴⁸

As a result of these policies the difference between the approach to VD in the lines and to that in the UK was a matter of context rather than through any ideological difference. The same preventative and prophylactic methods were available, lectures were given in both areas, and leave was still the most likely place for contracting illness. While soldiers in the forward areas who had VD were evacuated, they were not evacuated to 1ADH Bulford. Rather they were sent to the care of medical units immediately behind the lines for abortive treatment. VD was most often contracted on leave, but that did not stop the AAMC from seeking to prevent the cases that did occur closer to the front.

Why was Pragmatism Possible?

By early 1916 it had become clear that the moralist and disorganised approach to VD that had prevailed in the AIF was not sufficient to combat the constant flow of VD cases into

¹⁴⁶ Colonel RB Huxtable, 'Venereal Disease', 16 March 1918, War Diary Appendix 13, ADMS 1st Aust. Div. – March 1918, AWM: AWM4 26/18/40; Major WJ Stack for Colonel RB Huxtable, 21 May 1918, War Diary Appendix 10, ADMS 1st Aust. Div. – May 1918, AWM: AWM4 26/18/42.

¹⁴⁷ Colonel RB Huxtable, 'Venereal Disease', 16 March 1918, War Diary Appendix 13, ADMS 1st Aust. Div. – March 1918, AWM: AWM4 26/18/40.

¹⁴⁸ Major CL Chapman for DDMS Australian Corps, 'Medical Arrangements – Routine Order No. 3', 14 March 1918, War Diary Appendix 4, DDMS Australian Corps – March 1918, AWM: AWM4 26/17/3.

Australian military hospitals. Given the length of time taken to cure a man of VD once it had set in, it was far more efficient to prevent the infection or, if that was not possible, to treat it early. The role of the padre and organisations such as the YMCA as moral guardians and providers of wholesome diversions were never fully removed from the AIF. They played an important role in the prevention of disease and the entertainment of soldiers. But theirs were not the leading voices on VD for the AIF – that voice belonged to the AAMC. Once it became more organised and enlisted the expertise of a specialist dermatologist in George Raffan, the AAMC transformed the way VD was treated within the Australian army. Raffan, in conjunction with other officers such as Douglas McWhae and Bernhard Zwar, stepped away from the moralist approach previously dominant in the AIF and placed medical considerations at the forefront of the way the AAMC treated cases of VD. Even though Neville Howse was uncomfortable with these steps he allowed them to become AAMC policy.

The realisation that men on leave were at a greater risk of contracting VD provided the evidence needed to change the way the AAMC treated VD. The months immediately preceding and following the Dardanelles Campaign had high rates of infection and, after the majority of the AIF was relocated to France and England, the place most soldiers reported contracting VD was on leave in London. Once leave was acknowledged as a major factor in the army's attempts to combat VD and the punitive consequences put in place after the initial outbreak of VD were seen to have failed in their objectives, the army altered its approach once again to try to change the behaviour of its soldiers. It was clear to the army that fear of punishment was not sufficient to prevent soldiers from putting themselves at risk of contracting VD. The desire for sex was not outweighed by the fear of either disease or the punitive consequences of contracting it. Also, by turning the medical services into a force to be feared, the army had limited the AAMC's effectiveness in its attempts to combat the disease. Making the seeking of medical assistance something to be feared further perpetuated an already serious problem.

The medicalisation of the treatment of VD in the AIF was evident in the increasing authority the AAMC had over issues of both sexual illness and health. Advocates of a medical response were able to point to isolated successes where an individual Medical Officer had implemented a strategy and then harnessed it on a larger scale for the AAMC. This wider dissemination of evidence-based medicine reinforced the AAMC as an appropriate custodian of military medicine. Whilst there was continued involvement from

organisations such as the NCCVD and White Cross League, this was usually done in conjunction with the medical services. These groups did advocate a moralist approach to VD, which objected to any prevention methods that appeared to advocate vice, but their efforts were held in check by the pragmatic approach of the AAMC. Lisa Featherstone found that in the AAMC in the First World War “the overwhelming push was towards medicalising, rather than moralising, venereal disease”.¹⁴⁹ Featherstone’s conclusion is supported by the evidence presented in this chapter.

Michel Foucault, in *The History of Sexuality*, suggested that the confession had become an increasingly medicalised phenomenon. Sins were no longer confessed to priests in order to obtain absolution. He wrote:

The confession is a ritual discourse in which the speaking subject is also the subject of the statement; it is also a ritual that unfolds within a power relationship, for one does not confess without the presence (or virtual presence) of a partner who is not simply the interlocutor but the authority who requires the confession, prescribes and appreciates it, and intervenes in order to judge, punish, forgive, console, and reconcile.¹⁵⁰

Access to medical care required an act of confession, now anonymous, to be cleansed of disease.¹⁵¹ The attempts to protect the anonymity of the soldiers were put in place to engender trust between the Medical Officer and the soldier-patient. The punitive consequences originally handed to soldiers upon their confession of having contracted VD acted as deterrents from seeking medical assistance within the army rather than as deterrents from having sex. This made the AAMC a force to be feared in the eyes of the infected soldier. By shifting this confession into the private space between doctor and patient rather than officer and soldier the medical services were able to be of assistance to the soldier.

The pragmatic approach of the AAMC to VD was able to be implemented because it supported already entrenched gender roles. Lisa Featherstone’s study of sex in pre-war Australia found that chastity was the expected norm from both men and women but that it was socially acceptable for men to contravene this norm. She also found that the role of women as sites of disease was changing. Prostitutes remained guilty of this charge,

¹⁴⁹ Featherstone, *Let’s Talk about Sex*, 104.

¹⁵⁰ Michel Foucault, *The History of Sexuality*, vol. 1 (Melbourne: Penguin Books, 2008), 61–62.

¹⁵¹ Foucault, *The History of Sexuality*, 1:62.

however, current and future wives were increasingly constructed as the innocent victims of male promiscuity rather than as harbingers of disease. By lecturing men that the only way to avoid infection was to remain chaste at the same time as providing preventative and prophylactic treatments should they 'slip', the AAMC attempted to reinforce the ideal of chastity whilst expecting and anticipating errant behaviour. As the lectures given to soldiers demonstrate, this was done in large part to protect the efficiency of the army but also in the name of the women and future children of Australia. By maintaining disease as an external threat to the army, it was then possible to construct sexual incontinence as an offence against the soldiers' brothers-in-arms and therefore unpatriotic, rather than characterising it as merely scurrilous or incorrigible behaviour. This made contracting VD a crime against nation and wife; the soldier with VD was unpatriotic, and this was spelled out fairly explicitly to those in the AIF. It continues then that VD played a role in the development of soldiers' masculine and civic identity.

The AAMC adopted a pragmatic medically initiated and controlled approach to VD out of necessity and based on knowledge gained from civilian health care. The haphazard efforts of a few interested Medical Officers without any institutional support from the AAMC or the AIF resulted in VD becoming a significant problem for the AIF. This was not a surprise. VD had been associated with armies and navies for a long time and the correlation between war and increased VD rates was well-known among doctors and military officials of the time. The methods used in the prevention of VD by the AAMC in the first half of the First World War had simply failed. By continually preaching the importance of purity and chastity to soldiers and lecturing on the medical consequences of infection, yet simultaneously providing soldiers with prophylactic kits, early treatment depots and condoms, the AAMC reinforced the ideal of purity, the expectation that the ideal would be transgressed, and the medicalisation of the solution to the problem.

Conclusion

At the end of 1918 the Australian Army Medical Corps (AAMC) was a different organisation to the one that had first embarked for war in 1914. Commencing the war with a regular staff of four officers, the AAMC rapidly expanded and developed. Almost entirely dependent on assistance from Britain and the Royal Army Medical Corps (RAMC) at Gallipoli in 1915, the AAMC, over the course of the war, became more independent, developed its own practices and procedures, and asserted its expertise in order to have Australian medical control of Australian casualties in the First World War.

This thesis examines the structures of medical care that shaped medical provisions for the Australian Imperial Force (AIF) across three separate spheres: casualty clearance and evacuation in battle, rehabilitation after sickness or wounding, and the prevention and early treatment of venereal disease (VD). By analysing how, where, and by whom medical care was provided to Australian soldiers in the First World War, I have outlined the points at which imperial, military, medical and gender hierarchies were in competition for primacy. These hierarchies were under a constant process of renegotiation during the war and this thesis argues that despite the different pressures and priorities at the three different sites of care, the AAMC was consistent in its desire to develop and then maintain Australian medical control of AIF casualties.

By examining these structures of medical care, this thesis has made three key findings. First, it found there was a link between Gallipoli and the Western Front in the medical realm and demonstrated that not only did Australia's medical services reform the way they interacted with Britain after Gallipoli, but the success of the new arrangements at the Battle of Messines enabled Neville Howse to argue a few days later in front of the Dardanelles Commission that the AAMC was a capable provider of medical care during casualty evacuation. Second, I mapped the development of casualty clearance in the AAMC and showed the negotiations and discussions that informed the arrangements on the Western Front. My findings indicate that concerns over the proximity of medical units to the front and anxieties about the distance between those units and the relevant Casualty Clearing Station underpinned the various iterations of the medical arrangements. I also found that, in the changes to evacuation arrangements and the development of forward resuscitation teams, the AAMC was willing to depart from and work around British regulations.

Third, and most significantly, my findings demonstrate that Australian soldiers were not passive victims of venereal disease, nor were they reckless in their attitudes to their sexual health. Medical Officers for Australian units in the United Kingdom were required to report on the preventative methods used by men returning from leave and the collation of that data reveals that throughout 1918: 1) over sixty per cent of men going on leave accepted a preventative Blue Label Outfit; 2) around forty per cent of men going on leave purchased French Letters from the AIF; 3) over sixty per cent of men returning from leave sought prophylactic treatment; and 4) less than ten per cent of men returning from leave required abortive treatment. These statistics indicate that when provided with the relevant information and technologies, and when the disclosure of sexual activity was met with medical assistance rather than punishment, Australian soldiers were proactive in managing their sexual health. The responses to these findings that I have presented at international conferences suggest that they present a substantial contribution to the field.¹

As was noted at the beginning of this thesis, the First World War generally, and Gallipoli in particular, has been described as the moment in which the Australian nation was born. This view is problematic on many fronts, not least of which because Australia was federated fourteen years before the commencement of hostilities. Despite this, as far as the AAMC is concerned, Gallipoli was a turning point. The failures of the British military authorities to adequately plan for the evacuation of casualties during the initial landings and the August Offensive prompted the reorganisation and expansion of the Australian medical services.

Adherence to the traditional imperial hierarchy was detrimental to the evacuation of Australian casualties from Gallipoli. When Neville Howse, then Assistant Director of Medical Services for the 1st Australian Division, perceived problems with the structure of the medical arrangements, and alerted his superiors in the chain of command, his concerns were dismissed. At that stage the most senior member of the AAMC attached to the AIF, Surgeon General Williams, had no authority to direct Australian troops under the command of the Mediterranean Expeditionary Force. As Neville Howse was the highest-

¹ Alexia Moncrieff, "Managing Venereal Disease in the Australian Imperial Force during the First World War," in *Australian and New Zealand Society of the History of Medicine* (Missions, Methods and Management, Sydney, 2015); Alexia Moncrieff, "'Short-Arm' Parades and Venereal Disease Prevention in the Australian Imperial Force," in *Australian Women's History Network* (Flesh and Blood: A Feminist Symposium on Embodied Histories, Canberra, 2015); Alexia Moncrieff, "Venereal Disease and Emotion in the Australian Imperial Force, 1914-1918," in *Society for the Social History of Medicine* (Emotions, Health and Wellbeing, London, 2012).

ranked medical officer with the AAMC units deployed to Gallipoli he had no recourse to appeal decisions made by the British General Staff or the Royal Army Medical Corps.

When called before the Dardanelles Commission, which investigated the campaign, Howse was forthcoming with his criticism of those in command. His statements that the medical arrangements were such that they amounted to criminal negligence and that he would recommend that the Australian government never again entrust the medical care of its soldiers to imperial authorities were bold suggestions. He was able to make them with confidence, speaking many months after the Gallipoli evacuation, because the AAMC had just performed admirably during the evacuation of casualties from the Battle of Messines. That the plans at Gallipoli were no better for the British soldiers was immaterial; Howse and the AAMC were responsible to Australia for Australian casualties. This required them to maintain appropriate relationships within the military hierarchy of the British forces at the same time as reorienting their priorities to Australia first and the empire second.

In the time between the conclusion of the Dardanelles Campaign and the Battle of Messines, the AAMC had taken control of the medical arrangements for Australian units between the trench and the Casualty Clearing Station (CCS). There were still British officers involved – the Deputy Director of Medical Services at corps level was an officer in the RAMC – but at the Battle of Messines the AAMC officers discussed the arrangements between themselves and then communicated those decisions up the chain of command for approval rather than waiting for them to be handed down. These findings support the arguments previously made by historians Mark Harrison and Gary Sheffield, who have argued that the medical services were more integrated into military operations and that a more consultative command structure was in place on the Western Front compared to that in the Gallipoli campaign.²

Howse's push to have Australian control of Australian casualties was not that of an ardent nationalist. He argued that the medical services were primarily responsible Australian soldiers and would be held to account by the Australian public for the care they provided. Howse described himself as Englishman and "merely an adopted Australian".³ If the Australian government was never again going to rely on the British government to

² Mark Harrison, *The Medical War: British Military Medicine in the First World War* (Oxford: Oxford University Press, 2010), 120; Gary Sheffield, *The Chief: Douglas Haig and the British Army* (London: Aurum, 2011).

³ Surgeon General Sir NR Howse, Evidence to Dardanelles Commission q. 27676, The National Archives (UK): CAB 19/33.

make adequate arrangements for its wounded in any future conflict then Australia would need to be able to provide that service from its own resources. Howse saw the continued presence of unnecessary imperial officers as detrimental to morale and, in 1918, argued that the experience gained in more than three years of war was sufficient to counteract any perceived or actual deficiencies due to civilian medical men not having received military training to develop that military frame of mind so valued by Sir Ian Hamilton during the campaign in the Dardanelles. Howse's suggestion that the Australian army should have developed competent officers by that stage in the war and should be able to "stand on our own bottom"⁴ – i.e. be its own entity, responsible for its own governance – present the promotion of Australian medical men within the AAMC and the Australian Corps, and therefore the removal of replaceable imperial officers, as the next logical step in the development of the Australian army.

As imperial authority was gradually pushed out of the AAMC there was no corresponding movement to prevent British civilian involvement, with the proviso that military and medical authority were maintained. This is evident in the work of the AAMC at the 1st Australian Auxiliary Hospital at Harefield Park. At Harefield Park military interactions between British and Australian units were restricted to the point at which Australian soldiers recovering from wounding were handed over from British hospitals, which had responsibility for primary care, to the auxiliary hospital – a place of rehabilitation and recovery. Despite the lack of British military involvement in the auxiliary hospital, British civilian involvement was a daily occurrence. British civilians, especially women, took on a variety of paid and volunteer roles at Harefield Park in nursing positions, ward and household staff, and providing social care to recovering soldiers. This involvement was welcomed by the AAMC and, though it was subordinated to military and medical concerns, the different activities provided for the hospitals' patients by the local residents of Harefield were acknowledged as valuable and routinely recorded in the unit's war diaries thereby conferring legitimacy upon them. The relative frequency of marriages between local female residents of Harefield who worked in the hospital and Australian doctors and patients suggest that the AAMC's distrust of British actions after Gallipoli did not shift from the institutional and seep into personal relationships.

⁴ Surgeon General Sir NR Howse to Major General CBB White, 20 July 1917, Australian War Memorial: 2DRL/1351, Item 2.

British involvement in attempts to lessen the impact of venereal disease on the efficiency of the AIF was also limited. The RAMC was not substantially involved in this aspect of military medicine in the AIF and civilian efforts were restricted to those areas that supported the AAMC's efforts without undermining them. Australian soldiers were encouraged to take advantage of entertainment and activities provided by British charities and the AAMC leveraged the work of organisations concerned about the prevalence of VD in Britain. However, neither of these British civilian activities undermined the medical or military authority of the AAMC in this field. Therefore, while the war did not see the wholesale rejection of British involvement in the care of wounded Australian soldiers, where it was possible to have full Australian military-medical control of Australian sick and wounded then Australian authority was asserted and British intervention decreased.

During the First World War there was a distinction between military and civilian frames of mind. This was problematic for the AAMC. While the RAMC had a substantial permanent staff, the AAMC did not and the lack of a military mindset among doctors was one of the criticisms RAMC officers made of Neville Howse during the Dardanelles Commission. The privileging of full time medical-military men was a factor the RAMC itself would have to contend with as the war progressed and civilian doctors donned military uniforms in greater numbers. Yet, despite this supposedly underdeveloped military thinking in the AAMC, it still possessed military authority over soldiers. Its officers decided how, when and where soldier received medical care on the Western Front and used their military authority to create a system to reduce the impact of venereal disease. While initial attempts to do this using military discipline as a disincentive did not succeed, the altered plans in place after 1917 relied on the individual soldier taking responsibility for his own health while maintaining the threat of punishment if he did not adequately practise self-care. Even though the vast majority of doctors in the AAMC were civilians in uniform who had enlisted after the commencement of the First World War, they were willing and able to use the authority bestowed on them by their military position in order to provide adequate medical care to Australian soldiers.

Due to the nature of the AAMC it is difficult to separate military and medical hierarchies as the medical hierarchy was mapped onto the military hierarchy; however, the doctors in the AAMC did challenge the priorities of the army at various points. On the Western Front the large number of casualties posed a problem for the AAMC. The drive for efficiency required that those who were only slightly wounded be kept closer to the

front to enable a rapid return to duty; however, the scale of the casualties was such that the evacuation lines clogged up and bottlenecks occurred. In order to remedy this, over the course of 1916 and 1917, the AAMC altered the structure of the medical services from the front to the CCS. This resulted in an evacuation chain that only practised first aid closer to the front and moved casualties, with as little intervention as possible, back to more established and better equipped medical posts. In 1918, responding to the military situation, the AAMC retreated from some of its changes, reinstating aspects of the previous doctrine. Yet, it kept pushing to improve the care provided to wounded soldiers. The development of resuscitation teams in forward areas went against the prevailing wisdom on the level of treatment to be provided before evacuation. The AAMC officers concerned developed the plan and requested approval from RAMC officers to make the necessary alterations. This approval was not forthcoming but the AAMC officers proceeded anyway. They slightly altered their plans so that they adhered to the letter of the Field Service Regulations, not to the recommendation of the British Fourth Army's Director of Medical Services. The scheme was a success and it won the support of the Consulting Surgeon to the relevant CCS before being expanded. The AAMC had clearly developed an understanding of military strategy and doctrine by 1918 and this supports Neville Howse's view that any deficiencies existing early in the war had been overcome by after three years of warfare. These civilian doctors had adapted to, and learned to manipulate, their military environment in order to care for wounded Australian soldiers. The medical and military priorities were held in tension and though the AAMC routinely prioritised medical concerns it developed the ability to do so within the military restrictions in place, further cementing the blended medical-military hierarchy.

Gender hierarchies were expressed differently across the different forms of care provided by the medical services. Competing masculinities were on display at Gallipoli with Neville Howse's authority undermined and his expertise diminished by British descriptions of him as simply a General Practitioner from country NSW. This description was used despite his leadership of the AAMC in the Pacific, his service in the South African War (for which he was awarded a Victoria Cross), and his promotion to Director of Medical Services for the AIF. This wartime blending of military and gender hierarchies reinforced the difficulties faced by the civilian doctors in uniform in the AAMC.

Once women were incorporated into the medical spaces gender became a more pronounced issue. The initial employment of a mixed physiotherapy team at Harefield Park

challenged the gender hierarchy as female physiotherapists were treated as honorary officers. Despite being paid less than their male counterparts they then outranked some of the men as only a limited number were made officers, the rest were other ranks. The problem of these competing military and gender hierarchies was resolved by creating an all-female physiotherapy staff at the hospital. Ostensibly to promote unit cohesion, it also saved the AAMC money and was similar to the reasons given for the employment of female domestic labour in the hospital, though this had the added benefit of enabling the male labour to be redeployed. The female physiotherapists were placed in charge of unskilled male labour but this was to enable the more efficient functioning of the hospital in times of peak work. In these instances their medical knowledge was the source of their higher status, not their gender.

In its attempts to combat venereal disease the AAMC established competing narratives of masculinity. By the end of the war the ideal soldier was chaste and demonstrated self-control by abstaining from sex. Yet the AAMC knew from experience that this ideal was frequently transgressed so described the seeking of medical assistance and the use of preventative and prophylactic treatments before and after sex as more honourable than the disregard of sexual health. This did not contradict the widely held beliefs about male sexuality. Therefore gender hierarchies were not only present, but actively harnessed in the attempts of the AAMC to limit the effects of venereal disease on the AIF.

David Noonan's statistical analysis of the AIF called into question Butler's conclusions regarding the medical services in the First World War.⁵ This thesis found that, though based on incorrect statistical data, Butler's conclusions were generally sound. However, he was too willing to give credit for the successes of the AAMC to Neville Howse. While Howse certainly led the AAMC well and is responsible for the form of the medical services from 1916, he cannot be given credit for the success of the system of VD prevention. Howse was contrary and uncooperative in the initial discussions about VD prevention. He dismissed all suggestions made as either having been tried before or unlikely to work. Howse did eventually allow the pragmatic system to develop, but this

⁵ David Noonan, *Those We Forget: Recounting Australian Casualties of the First World War* (Melbourne: Melbourne University Press, 2014); Arthur G. Butler, *The Australian Army Medical Services in the War of 1914-1918: Gallipoli, Palestine and New Guinea*, vol. 1 (Melbourne: Australian War Memorial, 1938); *The Australian Army Medical Services in the War of 1914-1918: The Western Front*, vol. 2 (Canberra: Australian War Memorial, 1940); Arthur G. Butler, *The Australian Army Medical Services in the War of 1914-1918: Problems and Services*, vol. 3 (Canberra: Australian War Memorial, 1943).

only occurred after those below him in the hierarchy skilfully managed his abstemious views by building a consensus based on expertise and experience. This conclusion regarding Butler's Official History is in accordance with those of Mark Harrison and Michael Tyquin.⁶

Harrison's conclusions, that a more consultative approach to command existed on the Western Front (compared to that at Gallipoli) and that the medical services were increasingly integrated into military decision making are also supported by this thesis. I have used a similar approach to Harrison, but applied it to the AAMC rather than the RAMC to extend the analysis into the Australian medical services in more detail than is covered by Harrison. I do not differ substantially from Tyquin in my conclusions about Gallipoli but instead of examining it in isolation I have explicitly linked it to the Western Front in order to demonstrate that the former informed how medical care was provided once the AAMC relocated the majority of its personnel and equipment to Europe.

This thesis was driven by primary sources and is less theoretical than some of the cultural histories of medicine in war. Taking a different approach to Ana Carden-Coyne, I differ in my conclusions about how gender worked in medical-military spaces.⁷ I found that, in the Australian context, the activities provided by female volunteers at Harefield Park, including fancy work, basket weaving and painting, were not a challenge to the masculinity of the recovering soldiers. Instead, I argued that those activities, available to men whose bodies had been curtailed, were ordinarily located in the female realm and were indicative of the limited nature of activities available to women. Moreover, this structure reinforced the blending of medical and gender hierarchies with men practising medicine and women providing care. Conversely, I found that Jeffrey Reznick's conclusions can be applied to the Australian case. He found that there was a 'culture of caregiving' among British civilians that was demonstrated in the way they cared for British soldiers.⁸ As a result of research into the 1st Australian Auxiliary Hospital at Harefield Park, it is clear that the same culture of caregiving was extended to at least one of the dominions.

This thesis has been necessarily constrained in scope. It has neither incorporated the work of the Australian Army Medical Corps in Sinai and Palestine, nor the Australian

⁶ Harrison, *The Medical War*; Tyquin, *Gallipoli*.

⁷ Carden-Coyne, *The Politics of Wounds*.

⁸ Reznick, *Healing the Nation*.

Naval and Military Expeditionary Force's foray into the Pacific. The AIF's medical provisions in those campaigns, especially the former, would provide interesting cases for comparison with the provision on the Western Front and Gallipoli. The different landscapes and military contexts presented different problems for the medical corps and future comparative analyses would enable a discussion of whether the findings of this thesis, regarding the structures that improved and impeded access to medical care, could be extended and applied to different theatres of war.

The scope of this thesis excluded the space between the Casualty Clearing Station and the Auxiliary Hospital, which I have not examined except for the work of the AAMC in its attempts to combat venereal disease. The Australian Army Medical Corps had a significant presence behind the lines in France, where the medical units provided by Australia were a part of the broader British services. These broader responsibilities outside of the AIF draw the area outside the scope of this thesis. This international space is fertile ground for future studies of imperial cooperation and international medical networks. With the foundations already laid by Mark Harrison in his seminal work *The Medical War: British Military Medicine in the First World War*,⁹ there is space for further discussion of the role of formal and informal networks in the service of empire.

As this thesis has fundamentally dealt with medical decision making, and the examination of where responsibility for those decisions lay, I have not analysed the work of nurses in detail. In the AIF nurses worked as far forward as Casualty Clearing Stations so are largely outside the scope of the first three chapters of this thesis. Their role within the auxiliary hospital was discussed in Chapter 4 as they became responsible for managing aspects of civilian labour in the medical space and their roles were contrasted with those of the female physiotherapists in the hospital. Recent scholarship on nursing in the First World War is creating an increasingly sophisticated historiography of the work of nurses and is to be applauded. It is extending the field beyond hagiography and the documenting of nurses' service in order to interrogate the nature of the work and the professionalisation of nursing.¹⁰

⁹ Mark Harrison, *The Medical War*.

¹⁰ See for example: Alison S. Fell and Christine E. Hallett, eds., *First World War Nursing: New Perspectives* (New York: Routledge, 2013); Christine E. Hallett, *Veiled Warriors: Allied Nurses of the First World War* (Oxford: Oxford University Press, 2014); Christine E. Hallett, *Containing Trauma: Nursing Work in the First World War* (Manchester: Manchester University Press, 2009).

It is impossible to completely tease apart the four hierarchies under consideration in this thesis as they did not begin to interact at the commencement of the First World War. However, their relationships to each other were in a state of flux over the course of the war and altered based on the particular needs of the situations in which the AAMC worked. The debacle that was the medical arrangements for the campaign in the Dardanelles was an important moment for the AAMC. That was the point at which it became apparent to Neville Howse and other members of the AAMC that Australia could not afford to be reliant on British plans. Until at least the Dardanelles Commission hearings in 1917, if not for the rest of the First World War, the AAMC worked in Gallipoli's shadow. By locating that battle within the broader context of the First World War this thesis demonstrates one way that Gallipoli was significant in Australian military history. It was the stimulus that precipitated the transformation of the AAMC into a more independent unit with medical and military expertise of its own. As a result, the AAMC gained control and increasingly asserted its authority over sick, wounded and recovering Australian soldiers.

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